

NEW YORK CITY

Summary Program Description

Health Benefits Program



**The City of New York
Office of Labor Relations
Employee Benefits Program**

Introduction

The City of New York's Health Benefits Program

Employee/Retiree Responsibilities

Choosing a Health Plan

For More Information

Call the plans you are interested in for benefits packages and provider directories. Telephone numbers, addresses and web sites are listed at the end of each plan description.

Through collective bargaining agreements, the City of New York and the Municipal Unions have cooperated in choosing health plans and designing the benefits for the City's Health Benefits Program. These benefits are intended to provide you with the fullest possible protection that can be purchased with the available funding.

This Summary Program Description provides you with a summary of your benefits under the New York City Health Benefits Program. Health insurance and the health care system can be complicated and confusing. This booklet was developed to help you to understand your benefits and responsibilities under the New York City Health Benefits Program.

The plan you have chosen will send you an in-depth description of its benefits when you enroll. As a participant in the New York City Health Benefits Program, it is important that you know how your health plan works and what is required of you. The following are *some* of the important things that you need to remember:

- Complete an enrollment form to add newly-acquired dependents (newborn, adoption, marriage) within 31 days of the event;
- Notify your health plan and your agency in writing when your address changes;
- Review your payroll/pension check to ensure appropriate premiums are deducted;
- Report Medicare eligibility to your health plan and the Health Benefits Program;
- Know your rights and responsibilities under COBRA continuation coverage.

To select a health plan that best meets your needs, you should consider at least four factors . . .

Coverage . . . The services covered by the plans differ. For example, some provide preventive services while others do not cover them at all; some plans cover routine podiatric (foot) care, while others do not.

Choice of Doctor . . . Some plans provide partial reimbursement when non-participating providers are used. Other plans only pay for, or allow the use of, participating providers.

Convenience of Access . . . Certain plans may have participating providers or centers that are more convenient to your home or workplace. You should consider the location of physicians' offices and hospital affiliations.

Cost . . . Some plans require payroll and pension deductions for basic coverage. The costs of Optional Riders also differ. These costs are compared on charts in Section Four of this booklet. Some plans require a copayment for each routine doctor visit. Some plans require you to pay a yearly deductible and coinsurance before the plans will reimburse you for the use of non-participating providers. If a plan does not cover certain types of services that you expect to use, you must also consider the out-of-pocket cost of these services.

Section One

If You Need Assistance

Internet Access

You can access the Health Benefits Program web page via the official New York City Web site at: www.nyc.gov/olr.

Employees -- Employees should direct questions concerning eligibility, enrollment, paycheck deductions, or the Transfer Period, as well as requests for a Health Benefits Application, to their worksite agency health benefits, personnel or payroll office. Employees with questions relating to benefits, services, or claims should write or call their health plan. When writing to a health plan, include your name and address, certificate number, date(s) of service, and claim number(s), if applicable. Some plans also allow inquiries through their web sites.

Retirees -- Retirees with questions about benefits, services, or claims should write or call their health plan. When writing to the plan, give your certificate number, name and address. The Health Benefits Program is also available to provide service and information to City retirees who have questions about or problems with their health benefits or pension check deductions. Retirees contacting the Health Benefits Program should always include the following information:

PLEASE PRINT CLEARLY

- Name, Address and Telephone Number
- Social Security Number
- Pension Number

Whom Do I Contact after Retirement?

Retirees can contact the Health Benefits Program at:

City of New York Health Benefits Program
40 Rector Street - 3rd Floor
New York, NY 10006
(212) 513-0470
TTY/TDD: (212) 306-7753
or visit our website at: www.nyc.gov/olr

When Should I Call/Write/Visit the Health Benefits Program?

- For questions regarding deductions for health benefits taken from your pension check
- To obtain applications to make changes to your coverage such as adding/dropping dependents, adding/dropping the optional rider, waiving health coverage and to change plans (excluding Medicare HMOs, which require a special application from the plan)
- To obtain information and an application for COBRA benefits
- To change your address
- For notification of enrollment in Medicare
- For questions regarding Medicare Part B premium reimbursements
- If your health coverage has been terminated
- If a dependent has been terminated from your health plan

When Should I Contact My Health Plan?

(Refer to your health plan identification card or plan booklet for telephone numbers.)

- If you have questions regarding covered services
- To obtain written information about covered services
- For information about the status of pending claims or claim disputes
- For claim allowances (How much will a plan pay towards a claim?)
- If your health coverage has been terminated by your health plan
- If a dependent has been terminated from your health plan
- For health plan service areas
- To obtain a special application in order to enroll in a Medicare HMO

When Should I Contact My Union/Welfare Fund?

For information about:

- Prescription drug coverage (if applicable)
- Eyeglass coverage
- Dental benefits
- Life Insurance (if applicable)

Section Two

General Information

A. Costs

B. Eligibility

Double City Coverage Prohibited

If a person is eligible for the City program as both an employee/retiree or a dependent, the person must choose one status or the other. No person can be covered by two City health contracts at the same time. Eligible dependent children must all be enrolled as dependents of one parent. If both spouses or domestic partners are eligible and one is enrolled as the dependent of the other, the dependent may pick up coverage in his or her own name if the other's contract is terminated.

Enrollment

There is no cost for basic coverage under some of the health plans offered through the City Health Benefits Program, but others require a payroll or pension deduction. Enrollees may purchase additional benefits through Optional Riders for all plans except for DC 37 Med-Team. Employee deductions are made on a pre-tax basis. (See Medical Spending Conversion, page 4).

To be eligible for participation in the City Health Benefits Program, employees and retirees must meet all of the following criteria.

Employees are eligible if:

- a. You work -- on a regular schedule -- at least 20 hours per week; *and*
- b. Your appointment is expected to last for more than six months.

Retirees are eligible if:

- a. You have, at the time of retirement, at least ten (10) years of credited service as a member of a retirement or pension system maintained by the City (if you were an employee of the City on or before December 27, 2001, then at the time of your retirement you must have at least five (5) years of credited service as a member of a retirement or pension system maintained by the City). This requirement does not apply if you retire because of accidental disability; *and*
- b. You have been employed by the City immediately prior to retirement as a member of such system, and have worked regularly for at least 20 hours per week; *and*
- c. You receive a pension check from a retirement system maintained by the City.

EXCEPTIONS: Members of pension systems not maintained by the City may be eligible for health coverage pursuant to legislation or a collective bargaining agreement specifying such coverage.

Dependents are eligible if their relationship to the eligible participant is one of the following:

1. A legally married husband or wife, but never an ex-spouse.
2. A domestic partner at least 18 years of age, living together with the participant in a current continuous and committed relationship, although not related by blood to the participant in a manner that would bar marriage in New York State. More details concerning eligibility and tax consequences are available from your agency or the Office of Labor Relations Domestic Partnership Liaison Unit at 212-306-7605 (employees) or 212-513-0470 (retirees).
3. Children under age 26 (whether married or unmarried), except as provided below (relating to adult children eligible for other health coverage). **Effective July 1, 2011 the term "children" means the following:**
 - a. natural children;
 - b. children for whom a court has accepted a consent to adopt and for the support of whom an employee or retiree has entered into an agreement;
 - c. children required to be covered under a qualified medical child support order until the court order expires, at which time the child may continue to be eligible for coverage under (a) or (b) above;
 - d. children for whom a court of law has named the employee or retiree as legal guardian;
 - e. any other child who lives with an employee or retiree in a regular parent/child relationship and is the employee's or retiree's tax dependent. A child is the employee's or retiree's tax dependent if the employee or retiree claims the child on his/her income tax return as a dependent.
 - f. Unmarried children age 26 and older who cannot support themselves because of a disability, including mental illness, developmental disability, mental retardation or physical handicap are eligible for coverage if the disability occurred before the age at which the dependent coverage would otherwise terminate. Employees or retirees must provide medical evidence of the

disability. The proof of disability must be submitted to the health plan within 31 days of the date the dependent reaches age 26. Eligibility for such dependents only applies to current employees whose disabled dependent children reach the age limitation while covered by a City health plan. New employees with disabled dependent children already over the age limitation may not include such children as dependents on their City health plan coverage. In addition, employees may not add disabled dependent children to their health plan coverage, if the child is already over age 26.

Coverage will terminate for children reaching age 26 (other than eligible disabled children) at the end of the month in which the child reaches age 26.

C. How to Enroll For Health Benefits

1. As an Employee — To enroll, you must obtain and file a Health Benefits Application at your payroll or personnel office. The form must be filed within 31 days of your appointment date (for exceptions, see F, page 6). If you do not file the form on time, the start of your coverage will be delayed and you may be subject to loss of benefits.

New employees or employees enrolling for the first time are required to provide acceptable documentation to support the eligibility status of all persons to be covered on their City health plan coverage.

2. At Retirement — You must file a Health Benefits Application at your payroll or personnel office prior to retirement to continue your coverage into retirement. If you are Medicare-eligible and are enrolling in an HMO you must complete an additional application form, which must be obtained directly from the health plan.

3. After Retirement — To enroll, you must obtain a Health Benefits Application from the Health Benefits Program. Complete the form and file it with the Health Benefits Program. You must meet the eligibility requirements for health benefits coverage. If you are retired from a cultural institution, library, or the Fashion Institute of Technology, or if you receive a TIAA/CREF pension and are eligible for City health coverage, you must file a Health Benefits Application with your former employer.

D. Pre-Tax Funding Programs

Tax-favored Benefits

The City of New York Employee Benefits Program provides two programs, the Medical Spending Conversion (MSC) and Health Care Flexible Spending Account (HCFSA), that offer participants the opportunity to use pre-tax funds to increase take-home pay. These programs are administered through the Flexible Spending Accounts (FSA) Program.

Medical Spending Conversion (MSC) is comprised of two distinct programs: the Premium Conversion Program and the Health Benefits Buy-Out Waiver Program.

Premium Conversion Program

All employees who have payroll deductions for health benefits are automatically enrolled in the Premium Conversion Program. The Premium Conversion Program allows for premiums of health plan deductions on a pre-tax basis, thus reducing the amount of gross salary on which federal income and Social Security (FICA) taxes are calculated. The overall reduction in gross salary is shown on the Form W-2 at the end of the year, but no change is reflected in the gross salary amount on employees' paychecks. Employees may decline enrollment in the Premium Conversion Program when they first become eligible for health plan coverage or during the FSA Open Enrollment Period, which is in the fall of each calendar year. To do so, employees must complete an MSC Form and the Health Benefits Application and submit them for approval to their personnel office. The benefits or payroll officer completes the appropriate section on the MSC Form and forwards the forms to the FSA Administrative Office.

In accordance with IRS rules, participants cannot change their Premium Coverage Plan status except during the Open Enrollment Period or when experiencing a mid-year Qualifying Event.

A change in health plan status that results in a change in payroll deductions may only be made during the Transfer Period or within 31 days of a Qualifying Event.

Premium Conversion Program Qualifying Events

To do so, an MSC Premium Conversion Program Form, with the required documentation, must be submitted to the benefits officer during the Open Enrollment Period or within 31 days of the occurrence of the Qualifying Event, which include:

- A change in family status due to death, birth, adoption, marriage, divorce, annulment or legal separation between participant and spouse;
- The attainment of the maximum age for coverage of a dependent child;
- A court order requiring a recently divorced participant to provide health Insurance coverage for eligible dependent children;
- Moving out of an HMO service area;
- A change in title that necessitates a change in health plan;
- The termination of participant's employment for any reason including retirement;
- A change in the participant's employment status that results in a health insurance coverage change;
- A change in a spouse's employment status or a significant change in a spouse's health coverage that is outside the spouse's control (e.g., benefit reduction);
- The taking of, or returning from, an approved unpaid leave of absence by the participant or the participant's spouse;
- An increase in the employee's health plan premium deduction by more than 20%.

Employees Who Have Previously Waived or Cancelled Health Benefits Coverage

Eligible employees who have waived health benefits coverage may enroll for coverage subject to the waiting period described in Reinstatement of Coverage, page 10. Reinstatement of coverage is only possible within 31 days of a Qualifying Event or during the Open Enrollment Period. Such enrollment will be on a pre-tax basis (unless enrollment in the Premium Conversion Program is declined).

Effects of Premium Conversion Program on Health Benefits Program Rules and Procedures

IRS rules regarding the Premium Conversion Program require that an employee's health premium payroll deduction remains either pre-tax or post-tax for the entire Plan Year. Therefore, no change that would affect the amount of the deduction can be made unless a Qualifying Event has occurred. As a result, the following health plan changes can only be made within 31 days of a Qualifying Event or during the Open Enrollment Period:

- Change from family to individual coverage while an employee's dependents are still eligible for coverage; or
- Change from individual to family coverage if an individual's dependents were previously eligible for coverage; or
- Voluntary cancellation of coverage or the dropping of an Optional Rider while an employee is still eligible for such coverage or rider.

Health Benefits Buy-Out Waiver (Employees Only)

The MSC Health Benefits Buy-Out Waiver Program entitles all eligible employees to receive a cash incentive payment for waiving their City health benefits if non-City group health coverage is available to them (e.g., a spouse's/domestic partner's plan, coverage from another employer). Annual payments, which are taxable income, are \$500 for those waiving individual coverage and \$1,000 for those waiving family coverage. This amount will be prorated for any period less than six months by the number of days the employee is participating in the MSC Health Benefits Buy-Out Waiver Program.

Employees Who Return to Payroll Following Leave Without Pay (LWOP)

Employees will have 31 days from the date of the Qualifying Event to request a change.

Employees Who Return to Payroll Following Leave Without Pay (LWOP)

An employee who is on leave without pay during an Open Enrollment Period, upon return to payroll, will automatically be enrolled in the MSC Premium Conversion Program, unless declined within 30 days of such an event. To participate in the MSC Health Benefits Buy-Out Waiver Program, an eligible returning employee must complete both the MSC Health Benefits Buy-Out Waiver Program Form and the Health Benefits Application within 31 days of such an event.

Health Care Flexible Spending Account (HCFSA)

The Health Care Flexible Spending Account (HCFSA) Program is designed to help participants pay for necessary out-of-pocket medical, dental, vision, and hearing aid expenses not covered by insurance. HCFSA is funded through pre-tax payroll deductions (minimum - \$260 / maximum - \$5,000), thereby effectively reducing the participant's taxable income. Participants submit claims for eligible medical expenses to the FSA Administrative Office and receive a reimbursement check – not subject to federal income tax or Social Security tax (FICA) – from their HCFSA account. The amount of tax savings depends on the participant's income tax bracket and the amount contributed to HCFSA.

For more information, please contact your benefits manager or call the Pre-Tax Benefits Program at (212) 306-7760. The FSA brochure and the Enrollment/Change Form are available on the FSA web site at www.nyc.gov/html/olr.

E. Waiver of Health Benefits

Waiver of Health Benefits

Every employee or retiree eligible for City health benefits must either enroll for coverage or waive membership by completing the appropriate sections of the Health Benefits Application. (See Buy-Out Waiver Program, page 5). Those who waive or cancel City health plan coverage and subsequently wish to enroll or reinstate benefits will not have coverage until the beginning of the first payroll period 90 days after the submission of a Health Benefits Application, unless the participant has lost other group coverage.

F. Effective Dates of Coverage

Effective Dates of Coverage

Coverage becomes effective according to the following:

For Employees — For Provisional employees, Temporary employees, and those Non-Competitive employees for whom there is no experience or education requirement for employment, coverage begins on the first day of the pay period following the completion of 90 days of continuous employment, provided that your Health Benefits Application has been submitted within that period.

For All Other Employees — For employees appointed from Civil Service lists, Exempt employees, and those Non-Competitive employees for whom there is an experience or education requirement, coverage begins on your appointment date, provided your Health Benefits Application has been received by your agency personnel or payroll office within 31 days of that date.

For Eligible Dependents — Coverage for eligible dependents listed on your Health Benefits Application will begin on the day that you become covered. Dependents acquired after you submit your Application will be covered from the date of marriage, domestic partnership, birth or adoption, provided that you submit the required notification and documentation within 31 days of the event (see Changes in Family Status, A., page 8).

For Retirees — If you file the Health Benefits Application for continuation of coverage into retirement with your agency payroll or personnel office prior to retirement (ideally provide 4 to 6 weeks notice), coverage begins on the day of retirement for most retirees. *Employees who had previously waived coverage can reenroll upon retirement. The effective date of the reinstatement will be the date of retirement, or the first day of the month following the processing of the health benefits application.*

An enrollment is considered late if an application is filed more than 31 days after the event that made the employee, retiree, or dependent eligible. In cases of late enrollment, coverage will begin on the first day of the payroll period following the receipt of the application (for retirees, the first day of the month following the processing of a Health Benefits Application) by the agency payroll or personnel office.

Participation in the Medical Spending Conversion (MSC) Program may limit health plan enrollment and/or status changes. If such changes affect your health plan deductions, they must be made within 31 days of the Qualifying Event or they cannot be made at all until the next Transfer Period.

G. Optional Riders

All health plans, except DC 37 Med-Team have an Optional Rider consisting of benefits that are not part of the basic plan. You may elect Optional Rider coverage when you enroll and pay for it through payroll or pension deductions. Each rider is a package and you may not select individual benefits from the rider.

Many employees and retirees get additional health benefits through their welfare funds. *If your welfare fund is providing benefits similar to some (or all) of the benefits in your plan's Optional Rider, those specific benefits will be provided only by your welfare fund and will not be available through your health plan rider.* Pension and payroll deductions will be adjusted accordingly.

If the Optional Rider consists only of a prescription drug plan, and your union welfare fund provides prescription drug benefits, payroll or pension deductions will not be adjusted automatically to account for union welfare fund benefits if you select the optional rider. You will then pay for drug benefits through the rider and have those benefits from the rider in addition to your welfare fund. Participants in Medicare HMO plans should be aware that prescription drug benefits may be automatically included in their plan benefits.

H. Deductions for Basic Coverage and Optional Riders

1. From Paychecks — If there is a payroll deduction for your plan's basic coverage, or if you apply for an Optional Rider, your paycheck should reflect the deduction within two months after submitting a Health Benefits Application.

2. From Pension Checks — It may take considerable time before health plan deductions start from retirees' pension checks. Retroactive deductions (not to exceed \$35 a month in addition to the regular deduction) are then made to pay for coverage during the period from retirement to the time of the first deduction. Although deductions may not be taken for a month or more, your coverage still is in effect. When either you or a dependent becomes eligible for Medicare (by reaching age 65 or through disability), the amount deducted is adjusted after you notify the Health Benefits Program of Medicare coverage (see City Coverage for Medicare-Eligible Retirees, page 14). This adjustment may also take time to be processed.

3. Incorrect Deductions — If the deduction is incorrect, you *must* report the error within 31 days. Employees must contact their agency health benefits representative and retirees must contact the Health Benefits Program. Corrections will be made as quickly as possible after notification.

Changes in Enrollment Status

A. Changes in Family Status - Adding or Dropping Dependents

Participants should report all changes in family status to their personnel or payroll office (for employees) or the Health Benefits Program (for retirees). Use the Health Benefits Application to add dependents due to marriage, domestic partnership, birth or adoption of a child, and to drop dependents due to death, divorce, termination of domestic partnership, or a child reaching an ineligible age or losing full-time student status. Forms must be submitted within 31 days of the event. If a covered dependent loses eligibility, that person may obtain benefits through the COBRA Continuation of Benefits provisions described on page 11.

B. Change in Plan

Health Benefits Transfer Periods are usually scheduled once each year. During these periods, all *employees* may transfer from their current health plan to any other plan for which they are eligible, or they may add or drop Optional Rider coverage to their present plan. *Retirees may only participate in Transfer Periods that occur in even-numbered years.*

If you do not apply for an Optional Rider when you first enroll, you may add these additional benefits only during a Transfer Period, upon retirement, or if there is a change in your union or welfare fund coverage.

1. Annual Transfer Period (Employees)

Procedures for Employee Health Plan Transfers — In order to transfer from one plan to another or to add Optional Rider coverage, you must complete a Health Benefits Application, which is available from your agency payroll or personnel office. This form must be completed and returned to your payroll or personnel office during the annual Transfer Period.

See your agency Health Benefit representative, payroll or personnel office for the effective date of the change. ***Once you submit the Health Benefits Application your transfer is irrevocable.***

2. Retiree Transfer Opportunities

Retirees may transfer or add an Optional Rider during the even-numbered year Transfer Periods. Additionally, retirees who have been retired for at least one year can take advantage of a once-in-a-lifetime provision to transfer or add an optional rider at any time. Once-in-a-lifetime transfers become effective on the first of the month following the date that the Health Benefits Application is processed.**

C. Transfer into or out of Your Health Plan's Service Area

If you permanently move outside of your plan's service area, you may transfer within 31 days to another plan without waiting for the next Transfer Period. Also, if you move into the service area of a plan, you may transfer within 31 days to that plan.**

**Exception: When transferring into a Medicare HMO plan other than during Transfer Periods, transfers will become effective on the first day of the month following the processing of the special health plan application provided by the health plan.

Required Documentation

Appropriate documentation of marital status, domestic partnership, or dependent child relationship is required. This documentation may consist of a marriage, domestic partnership or birth certificate; adoption or guardianship papers; or copies of tax returns indicating a child is claimed as a dependent.

D. Leave of Absence Coverage

Special Leave of Absence Coverage (SLOAC) — SLOAC may provide continued City health coverage for specified periods of time to certain employees who are on authorized leave without pay as a result of temporary disability or illness, or who are receiving Workers' Compensation. Contact your payroll or personnel office for details.

Family and Medical Leave Act (FMLA) — The Federal Family and Medical Leave Act of 1993 ("FMLA") entitles eligible City employees to 12 weeks of family leave in a 12-month period to care for a dependent child or covered family member, and/or for the serious illness of the employee. Employees using this leave may be able to continue their City health coverage through the FMLA provisions. Contact your payroll or personnel office for details.

E. Change of Address

If you change your address be sure to notify your health plan and your agency so that your records can be kept up-to-date. Always provide your certificate or identification number when communicating with health plans.

Retirees should notify the Health Benefits Program, in writing, of any address change.

F. Transfer from One City Agency to Another

If you leave the employment of one City agency and you are covered under the City's Health Benefits Program, and subsequently become employed by another City agency and you are eligible to enroll for health coverage, your coverage will become effective on your appointment date at the new agency, provided that no more than 90 days have elapsed since your coverage terminated at the first agency. Your new agency should reinstate your coverage. (See Termination and Reinstatement, B. page 10). You may only change health plans during the annual Transfer Period.

If more than 90 days have elapsed, the Effective Dates of Coverage rules specified on page 6 apply. You must complete a new Health Benefits Application.

G. Change of Union or Welfare Fund Membership

Title changes that result in a change of union or welfare fund membership may require a change in payroll deductions for any Optional Rider coverage. You must contact your agency benefits representative within 31 days if you have changed union or welfare fund.

Termination and Reinstatement

A. When Coverage Terminates

Coverage terminates:

- for an employee or retiree and covered dependents, when the employee or retiree stops receiving a paycheck or pension check (with the exception of employees on SLOAC or FMLA).
- for a spouse, when divorced from an employee or retiree.
- for a domestic partner, when partnership terminates.
- for all dependents, unless otherwise eligible, when the City employee or retiree dies.

If both husband and wife, or domestic partner, are eligible for City health coverage as either an employee or a retiree, and one is enrolled as the dependent of the other, the person enrolled as dependent may pick up coverage in his/her own name within 31 days if the employee/retiree leaves City employment or dies.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the plan administrator issue certificates of group health plan coverage to employees upon termination of employment that results in the termination of group health coverage. Each individual, upon termination, will receive a certificate of coverage from the plan administrator. This certificate provides the necessary information to certify coverage that will be credited against any pre-existing condition exclusion period provided under a new health plan.

B. Reinstatement of Coverage

If you have been on approved leave without pay, or have been removed from active pay status for any other reason, your health coverage may have been interrupted. Contact your agency health benefits representative within 31 days of your return to work in order to complete a new Health Benefits Application. If you are returning from an approved leave of absence or your coverage has been terminated for less than 90 days, coverage resumes on the date you return to work. If you were not on an approved leave of absence or if your coverage has been terminated for more than 90 days, the effective date of coverage rules specified on page 6 apply.

If you have waived or cancelled your City health plan coverage and subsequently wish to enroll or reinstate your benefits, your coverage will not start until the beginning of the first payroll period 90 days following the date you submit your Health Benefit Application unless the enrollment or reinstatement is the result of a loss of other group coverage.

Options Available When City Coverage Terminates

A. Conversion Option

Employees and covered dependents may purchase individual health coverage through their health plan if their City group coverage ceases for any of the following reasons:

- an employee leaves City employment;
- an employee loses City coverage due to a reduction in the work schedule;
- an employee or retiree dies;
- a dependent spouse is divorced from the employee or retiree;
- a domestic partnership terminates;
- dependent children exceed the age limits established under the group contract;
- coverage under the provisions of COBRA (see B. following) expires.

Unlike COBRA, benefits under this type of policy do not automatically terminate after a limited time, and may vary from the City's "basic" benefits package in both the scope of benefits and in cost.

B. COBRA Benefits

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that the City offer employees, retirees and their families the opportunity to continue group health and/or welfare fund coverage in certain instances where the coverage would otherwise terminate. The monthly premium will be 102% of the group rate (or 150% of the group rate for the 19th through 29th month in cases of total disability, see B.2). All group health benefits, including Optional Riders, are available. The maximum period of coverage is 36 months.

1. COBRA Eligibility

The following are eligible for continuation of coverage under COBRA:

Employees Not Eligible for Medicare — Employees whose health and/or welfare fund coverages are terminated due to a reduction in hours of employment or termination of employment (for reasons other than gross misconduct). Termination of employment includes unpaid leaves of absence of any kind. More information concerning situations involving termination due to gross misconduct is available from your agency benefits representative.

Spouses/Domestic Partners Not Eligible for Medicare — Spouses/Domestic Partners who lose coverage for any of the following reasons: 1) death of the City employee or retiree; 2) termination of the employee's City employment (for reasons other than gross misconduct); 3) loss of health coverage due to a reduction in the employee's hours of employment; 4) divorce from the City employee or retiree; 5) termination of domestic partnership with the City employee or retiree; 6) retirement of the employee.

Dependent Children Not Eligible for Medicare — Dependent children who lose coverage for any of the following reasons: 1) death of a covered parent (the City employee or retiree); 2) the termination of a covered parent's employment (for reasons other than gross misconduct); 3) loss of health coverage due to the covered parent's reduction in hours of employment; 4) the dependent ceases to be a "dependent child" under the terms of the Health Benefits Program; 5) retirement of the covered parent.

Note

Individuals covered under another group plan are not eligible for COBRA continuation benefits unless the other group plan contains a pre-existing condition exclusion. However, these people may be able to purchase certain welfare fund benefits. For more information, contact the appropriate fund.

Special Notes for Medicare-Eligibles

Those who have lost coverage because of termination of employment or reduction in hours of the participant are eligible under the City's Medicare-supplemental plans for up to 36 months after the original qualifying event.

If a COBRA qualifying event occurs and you lose coverage, but you and/or your dependents are Medicare-eligible, you may continue coverage by using the COBRA Continuation of Coverage application form. You should indicate your Medicare claim number and effective dates where indicated on the form for Medicare-eligible family members. If you and/or your dependents are about to become eligible for Medicare, and are already continuing coverage under COBRA, inform your health plan of Medicare eligibility for you and/or your dependents at least 30 days prior to the date of Medicare eligibility. COBRA-enrolled dependents of the person who becomes Medicare-eligible will be able to continue their COBRA coverage, whether or not the Medicare-eligible person enrolls in the Medicare-Supplemental coverage. The COBRA continuation period for dependents will be unaffected by the decision of the Medicare-eligible employee or retiree.

Contact your health plan for information about other Medicare-Supplemental plans that are offered; some other health plans may be better suited to your needs and/or less costly than the plan that is provided under the City's contract.

Retirees – Retirees who are not eligible to receive City-paid health care coverage (see Eligibility, page 3) and their dependents (if not Medicare-eligible) may continue the benefits received as an active employee for a period of 36 months at 102% of the group cost under COBRA. Retirees eligible for Medicare should refer to the Medicare-Eligibles section on page 14. Retirees whose welfare fund benefits would be reduced or eliminated at retirement are eligible to maintain those benefits under COBRA for 18 months at 102% of the cost to the union welfare fund. Contact the union welfare fund for the premium amounts and benefits available. A list of welfare fund administrators can be obtained from City payroll or personnel offices.

2. COBRA Periods of Continuation

If benefits are lost due to termination of employment or reduction of work schedule, the maximum period for which COBRA can continue is 36 months. This period will be calculated from the date of loss of coverage under the City program.

However, if a beneficiary becomes disabled (as determined under Title II or XVI of the Social Security Act) during the first 60 days of the 18-month COBRA continuation period, coverage can be extended for an additional 11 months after the end of the original continuation period. Notification must be made to the plan administrator within 60 days after the Social Security Administration's determination of disability and before the end of the initial 18-month COBRA continuation period. The plan administrator must also be notified within 30 days if the Social Security Administration determines that the disability no longer exists. The otherwise applicable COBRA premium, i.e., 150% of the premium, must be paid during any extension period.

If dependents lose benefits as a result of death, divorce, domestic partnership termination, or loss of coverage due to the Medicare-eligibility of the contract holder, or due to the loss of dependent child status, the maximum period for which COBRA can continue coverage is 36 months. This period will be calculated from the date of the loss of coverage under the City program.

The definition of a qualified beneficiary includes a child born to or adopted by certain qualified beneficiaries during the COBRA continuation period. Only if you are a qualified beneficiary by reason of having been an employee, will a child born to or adopted by you during the COBRA continuation period become a qualified beneficiary in his or her own right. This means that if you should lose your COBRA coverage, your new child may have an independent right to continue his or her coverage for the remainder of the otherwise applicable continuation period. However, you must cover your new child as a dependent within 30 days of the child's birth or adoption in order to have this added protection.

Any increase in COBRA premium due to this change must be paid during the period for which the coverage is in effect.

Continuation of coverage can never exceed 36 months in total, regardless of the number of events that relate to a loss in coverage. Coverage during the continuation period will terminate if the enrollee fails to make timely premium payments or becomes enrolled in another group health plan (unless the new plan contains a pre-existing condition exclusion).

3. COBRA Notification Responsibilities

Under the law, the employee or family member has the responsibility of notifying the City agency payroll or personnel office and the applicable welfare fund within 60 days of the death, divorce, domestic partnership termination, or change of address of an employee, or of a child's losing dependent status. Retirees and/or the family members must notify the Health Benefits Program and the applicable welfare fund within 60 days in the case of death of the retiree or the occurrence of any of the events mentioned above.

Employees who are totally disabled (as determined by Social Security) up to 60 days after the date of termination of employment or reduction of hours must notify their health plan of the disability. The notice must be provided within 60 days of Social Security's determination and before the end of the 18-month continuation period. If Social Security ever determines that the individual is no longer disabled, the former employee must also notify the health plan of this. This notice must be provided within 30 days from Social Security's final determination.

When a qualifying event (such as an employee's death, termination of employment, or reduction in hours) occurs, the employee and family will receive a COBRA information packet from the City describing continuation coverage options.

4. Election of COBRA Continuation

To elect COBRA continuation of health coverage, the eligible person must complete a "COBRA - Continuation of Coverage Application." Employees and/or eligible family members can obtain application forms from their agency payroll or personnel office. Retirees' eligible family members can obtain application forms by contacting the Health Benefits Program. Please contact the welfare fund if you wish to purchase its benefits.

Eligible persons electing COBRA continuation coverage must do so within 60 days of the date on which they receive notification of their rights, and must pay the initial premium within 45 days of their election. Premium payments will be made on a monthly basis. Payments after the initial payment will have a 30-day grace period.

5. COBRA Transfer Opportunities

Former employees and dependents who elect COBRA continuation coverage are entitled to the same benefits and rights as employees. Therefore, COBRA enrollees may take part in the annual Transfer Period. Dependents of retirees enrolled in COBRA continuation coverage will continue to receive the same transfer opportunities available to retirees: once-in-a-lifetime transfer (if not already used), and transfer during the normal Transfer Period for retirees.

Individuals eligible for COBRA may also transfer when a change of address allows or eliminates access to a health plan that requires residency in a particular Zip Code.

The COBRA application form to be used during the Transfer Period (or after a qualifying event) can be obtained from the Health Benefits Program website at www.nyc.gov/olr in the pdf titled COBRA Notice of Rights and COBRA rates. Applications should be mailed to the COBRA enrollee's current health plan, which will forward enrollment information to the new health plan. Transfer Period changes will become effective on January 1st of the following year. Information about the effective date for a transfer made as the result of a qualifying event must be obtained from the new health plan.

City agencies do not handle COBRA enrollee transfers, or process any future changes such as adding dependents. All future transactions will be handled by the health plan in which the person eligible for COBRA is enrolled.

C. Special Continuation of Coverage

Effective November 13, 2001, New York State law provides that surviving spouses of retired uniformed members of the New York City Police and Fire Departments can continue their health benefits coverage for life. Effective August 30, 2010, New York State law provides that surviving spouses/domestic partners and dependents of members of the Departments of Sanitation and Correction are also eligible to continue their health benefits coverage for life. Such coverage will be at a premium of 102% of the group rate and must be elected within one (1) year of the date of the death of the member. Contact the Health Benefits Program, in writing, to obtain an application.

D. Disability Benefits

Those who are totally disabled because of an injury or illness on the date of termination remain covered for that disability up to a maximum of 18 additional months for the GHI-CBP/EBCBS plan and up to 12 months for all other plans, except GHI Type C/EBCBS, which provides only 31 days of additional coverage. This extension of benefits applies only to the disabled person and only covers the disabling condition. Under the GHI/Blue Cross plans, if a subscriber is hospitalized at the time of termination, hospital coverage is extended only to the end of the hospitalization. Contact the specific health plan for details.

City Coverage for Medicare-Eligible Retirees (Employees over age 65, see page 15)

Medicare – Your First Level of Health Benefits

When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare.

The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. *In order to maintain maximum health benefits, it is essential that you join Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) at your local Social Security Office as soon as you are eligible. If you do not join Medicare, you will lose whatever benefits Medicare would have provided.*

The City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare. Medicare-eligibles must be enrolled in Medicare Parts A and B in order to be covered by a Medicare HMO plan.

A. Medicare Enrollment

To enroll in Medicare and assure continuity of benefits upon becoming age 65, contact your Social Security Office during the three-month period before your 65th birthday. *In order not to lose benefits, you must enroll in Medicare during this period even if you will not be receiving a Social Security check.*

If you are over 65 or eligible for Medicare due to disability and did not join Medicare, contact your Social Security Office to find out when you may join. If you do not join Medicare Part B when you first become eligible, there is a 10% premium penalty for each year you were eligible but did not enroll. In addition, under certain circumstances there may be up to a 15-month delay before your Medicare Part B coverage can begin upon re-enrollment.

If you or your spouse are ineligible for Medicare Part A although over age 65 (reasons for ineligibility include non-citizenship or non-eligibility for Social Security benefits for Part A), contact:

**N.Y.C. Health Benefits Program
40 Rector Street - 3rd Floor
New York, NY 10006**

Coverage for those not eligible for Medicare Part A can be provided under certain health plans. Under this Non-Medicare eligible coverage, you continue to receive the same hospital benefits as persons not yet age 65.

If you are living outside the USA or its territories, Medicare benefits are not available. Under this Non-Medicare eligible coverage, you continue to receive the same hospital and/or medical benefits as persons not yet age 65. If you do not join and/or do not continue to pay for Medicare Part B however, you will be subject to penalties if you return to the USA and attempt to enroll. Please provide full identifying information, including name, date of birth, address, agency from which retired, pension number, health plan and certificate numbers, health code, Social Security Number and Medicare claim number (if any). Also give the reason for ineligibility for Medicare Part A and/or Part B.

If you are eligible for Medicare Part B as a retiree but neglect to file with the Social Security Office during their enrollment period (January through March) or prior to your 65th birthday, you will receive supplemental medical coverage only, and only through GHI/EBCBS Senior Care.

B. Medicare Eligibility

You must notify the Health Benefits Program in writing immediately upon receipt of your or your dependent's Medicare card. Include the following information: a copy of the Medicare card and birth dates for yourself and spouse, retirement date, pension number and pension system, name of health plan, and name of union welfare fund.

Once the Health Benefits Program is notified that you are covered by Medicare, deductions from your pension check will be adjusted, if applicable, and you will automatically receive the annual Medicare Part B premium reimbursement (See C., Medicare Premium Reimbursement). The Health Benefits Program will then notify your health plan that you are enrolled in Medicare so that your benefits can be adjusted. If you are Medicare-eligible and are enrolling in an HMO you must complete an additional application form, which is available directly from the plan. If your plan does not provide coverage for Medicare enrollees, you will have the opportunity to transfer to another plan that does.

C. Medicare Part B Reimbursement

The City will reimburse retirees for the basic monthly premium for Medicare Part B, as well for their eligible dependents on Medicare.

If you are receiving a Social Security check, the premium for Medicare Part B will be deducted from that check monthly. If you are not receiving a Social Security check, you will be billed on a quarterly basis by the Social Security Administration. You must be receiving a City pension check and be enrolled as the contract holder for City health benefits in order to receive reimbursement for Part B premiums. For most retirees, the refund is issued automatically by the Health Benefits Program, 40 Rector Street, 3rd Floor, New York, NY 10006, telephone (212) 513-0470. Medicare Part B reimbursement checks are generally issued once a year.

Special Provisions for Medicare-Eligible Employees

A. Special Provisions

Federal law requires the City of New York to offer employees over 65 the same coverage under the same conditions as offered to employees under 65. The same stipulation applies also to dependents over 65 and those covered by Medicare through the Special Provisions of the Social Security Act for the Disabled.* In such cases, enrollment in the City health plan is automatic (unless waived) and Medicare becomes secondary coverage.

If you are a Medicare-eligible employee and want Medicare to be your primary coverage, you must complete the waiver section of the Health Benefits Application and return it to your agency payroll or personnel office. If you do so, you will not be eligible for the City's group health plan.

Employees and their dependents covered by Medicare have identical benefits to those provided to employees and their dependents under age 65. Because of the cost of these benefits, the City does not reimburse employees or dependents for their Medicare Part B premiums if the City health plan is primary.

Medicare Part B premium reimbursement will be available at retirement when Medicare becomes the primary plan.

*The rules are somewhat different for persons eligible for Medicare due to end-stage renal disease. Consult your Medicare Handbook or agency health benefits representative for further information.

B. Retirement

At retirement, employees who have chosen Medicare as their primary plan or whose dependents have not been covered on their plan because their spouse/domestic partner elected Medicare as the primary plan may re-enroll in the City health benefits program. This is done by completing a Health Benefits Application and submitting it to their agency health benefits, payroll or personnel office.

Also at retirement, Medicare-eligible employees for whom the City Health Benefits Program had provided primary coverage are permitted to change health plans effective on the same date as their retiree health coverage.

C. Medicare Enrollment

Medicare Medical Insurance (Part B) is voluntary with a monthly premium that is subject to change. If you and/or your dependents choose City health coverage as primary, Medicare will be supplementary to any City health plan.

There are no penalties for late enrollment in Medicare Part B if employees choose the Health Benefits Program as primary coverage and cancel or delay enrollment in Medicare Part B coverage until retirement or termination of employment (when Medicare enrollment is permitted for a limited period of time). Medicare Hospital Insurance (Part A) should be maintained. For most persons, Part A coverage is free.

Coordination of Benefits (COB)

A. General

You may be covered by two or more group health benefit plans that may provide similar benefits. Should you have services covered by more than one plan, your City health plan will coordinate benefit payments with the other plan. One plan will pay its full benefit as a primary insurer, and the other plan will pay secondary benefits. This prevents duplicate payments and overpayments. In no event shall payments exceed 100% of a charge.

B. Rules of Coordination

The City program follows certain rules that have been established to determine which plan is primary; these rules apply whether or not you make a claim under both plans.

The rules for determining primary and secondary benefits are as follows:

1. The plan covering you as an employee is primary before a plan covering you as dependent.
2. When two plans cover the same child as a dependent, the child's coverage will be as follows:
 - The plan of the parent whose birthday falls earlier in the year provides primary coverage
 - If both parents have the same birthday, the plan that has been in effect the longest is primary.
 - If the other plan has a gender rule (stating that the plan covering you as a dependent of a male employee is primary before a plan covering you as a dependent of a female employee), the rule of the other plan will determine which plan will cover the child. (See Section C for special rules concerning dependents of separated or divorced parents.)
3. If no other criteria apply, the plan covering you the longest is primary. However, the plan covering you as a laid-off or retired employee, or as a dependent of such a person, is secondary, and the plan covering you as an active employee, or as a dependent of such a person, is primary, as long as the other plan has a COB provision similar to this one.

**C. Special Rules
for Dependents
of Separated
or Divorced
Parents**

If two or more plans cover a dependent child of divorced or separated parents, benefits are to be determined in the following order:

1. The plan of the parent who has custody of the child is primary.
2. If the parent with custody of a dependent child remarries, that parent's plan is primary. The step-parent's plan is secondary and the plan covering the parent without custody is third.
3. If the specific decree of the court states one parent is responsible for the health care of the child, the benefits of that parent's plan are determined first. You must provide the appropriate plan with a copy of the portion of the court order showing responsibility for health care expenses of the child.

**D. Effect of
Primary and
Secondary
Benefits**

1. Benefits under a plan that is primary are calculated as though other coverage did not exist.
2. Benefits under a plan that is secondary will be reduced so that the combined payment or benefit from all plans are not more than the actual charges for the covered service. The plan that is secondary will never pay more than its full benefits.

The Employee Blood Program

Your health plan covers the cost of administering transfusions and pays blood processing fees for employees, retirees and eligible family members. It does not pay for the storage of your own blood for future use.

Blood replacement fees are not covered by any health plan offered by the City. To help our community maintain blood reserves the Employee Blood Program sponsors a voluntary donor program for City employees, called the City Donor Corps. City Donor Corps members who donate once a year are entitled to certain benefits for themselves and family members. For further information, see your agency Blood Program Coordinator.

Section Three

Employee Assistance Programs

The City of New York's Employee Assistance Programs

The City of New York's Employee Assistance Programs (EAPs) are staffed by professional counselors who can help employees and their eligible dependents handle problems in areas such as stress, alcoholism, drug abuse, mental health, and family difficulties. An EAP will provide education, information, counseling and individualized referrals to assist with a wide range of personal or social problems. If you don't have an EAP in your own agency or union, you can call the New York City Employee Assistance Program (listed below) for information.

The New York City Employee Assistance Program gives you free, personal and quick access to referrals for professional help. An employee's contact with this service is private, privileged and strictly confidential. No information will be shared with anyone at any time without your written consent. More information can be found on our website on www.nyc.gov/olr.

Employees of the Police and Correction Departments and those in the Probation Officer title series may use their agencies' EAPs or the New York City EAP for alcohol abuse treatment services. If you wish to use substance abuse treatment services you must self-refer through your health plan.

Bellevue Hospital Center
Employee Assistance Program
(212) 562-4010

Department of Correction
Employee Assistance Program
(212) 487-7466

DC 37 Health & Security
Personal Service Unit
(212) 815-1250

Elmhurst Hospital Center
Employee Assistance Program
(718) 334-2216

Fire Department
Counseling Service Unit
(212) 570-1693
www.nyc.gov/fdny

Housing Authority
Employee Assistance Program
(212) 306-7660

New York City
Employee Assistance Program
(212) 306-7660
www.nyc.gov/olr

New York City Police
Police Organization Providing
Peer Assistance (POPPA)
Members Assistance Program
(212) 298-9111
www.poppanewyork.org

Queens Hospital
Employee Assistance Program
(718) 883-4214

Police Department
Counseling Service
(718) 834-8433

Department of Sanitation
Employee Assistance Unit
(917) 237-5867

United Federation of Teachers
Professional Staff:
(212) 598-7749
Paraprofessional Staff:
(212) 598-9506

Summary of Health Plans

- I. Point of Service Plans (POS)
Exclusive Provider Organizations (EPO)
Participating Provider Organizations (PPO)/
Indemnity Plans
- II. Health Maintenance Organizations (HMOs)
- III. Health Plans for Medicare-Eligible Retirees

The health plan summary descriptions and comparison charts contained in this booklet are for informational purposes only and are subject to change. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

**Exclusive Provider Organization (EPO),
Point-of-Service (POS) and
Participating Provider Organization (PPO)/Indemnity Plans
(For Employees and Non-Medicare Retirees and their dependents)**

Exclusive Provider Organization (EPO) plans offer a higher level of choice and flexibility than many other managed care plans. Members can see any provider in the EPO network, which contains family and general practitioners as well as specialists in all areas of medicine. There is no need to choose a primary care physician and no referrals are necessary to see a specialist. An EPO provides members with an extensive local, national and worldwide network of providers. There are no claim forms to file and members will never have to pay more than the copayment for covered services. There is no out-of-network coverage.

Point-of-Service (POS) plans offer the freedom to use either a network provider or an out-of-network provider for medical and hospital care. If the subscriber uses a network provider, health care delivery resembles that of a traditional HMO, with prepaid comprehensive coverage and little out-of-pocket costs for services. When the subscriber uses an out-of-network provider, health care delivery resembles that of an indemnity insurance product, with less comprehensive coverage and subject to deductibles and/or coinsurance.

Participating Provider Organization (PPO)/Indemnity plans offer the freedom to use either a network provider or an out-of-network provider for medical and hospital care. Participating Provider Organization (PPO)/Indemnity plans contract with health care providers who agree to accept a negotiated lower payment from the health plan, with copayments from the subscribers, as payment in full for medical services. When the subscriber uses a non-participating provider, the subscriber is subject to deductibles and/or coinsurance.

**The following Point-of-Service, Exclusive Provider Organization,
and Participating Provider Organization/Indemnity plans are
offered by the Health Benefits Program**

| Health Plan | Phone Number | Web Address |
|-------------------------------------|---------------------|--|
| DC 37 Med-Team (DC 37 members only) | (212) 501-4444 | www.ghi.com |
| Empire EPO | (800) 767-8672 | www.empireblue.com/nyc |
| GHI-CBP/Empire BlueCross BlueShield | | |
| Group Health Incorporated: | (212) 501-4444 | www.ghi.com |
| Empire BlueCross BlueShield: | (800) 433-9592 | www.empireblue.com/nyc |
| HIP Prime POS | (800) 447-6929 | www.emblemhealth.com |

Special Note

If a Medicare-eligible retiree is enrolled in a Medicare HMO or a Medicare supplemental plan and has non-Medicare eligible dependents, the corresponding plans on pages 21 through 27 provide benefits for those dependents. For information about Medicare enrollee coverage, please refer to the health plans on pages 42 through 48.



DC 37 Med-Team

The DC 37 Med-Team health insurance plan is offered to DC 37 Med-Team active employees and non-Medicare eligible retirees living in the states of New York and New Jersey. You may choose in-network or out-of-network providers. There is no payroll deduction for this plan.

Some advantages of the DC 37 Med-Team health insurance plan:

- You can get care at any of the more than 151,000 locations in the GHI-CBP (Comprehensive Benefits Plan) and Qualcare networks without a doctor's referral. GHI's network has many of the best doctors in the area, including all cancer specialists at Memorial Sloan-Kettering Cancer Center.
- You can receive benefits for covered services even when you choose out-of-network doctors. Remember that your out-of-pocket costs are lowest when you receive care in-network.
- You never need a physician referral to see a specialist.
- No copays are required for in-network office visits and diagnostic tests like X-rays or lab work for unmarried dependent children through the end of the year in which they reach age 19.
- There are educational programs for eligible members to learn to manage chronic conditions such as asthma and diabetes.
- Through the personalized myGHI section of GHI's website www.ghi.com, you can find a doctor, check you benefits and claim status, order ID cards, keep an online personal health record and more.
- There are discounts on health care products and services and the latest news on consumer health and medical issues on GHI's website www.ghi.com.

Hospitals: The DC 37 Med-Team Program provides in-network benefits at hospitals located in the states of New York and New Jersey which have been designated by GHI as being part of the network available to members of DC 37 Med-Team.

Emergency Care: Emergency care is covered as an in-network benefit in any hospital in the United States. There is a \$50 emergency room copay which is waived if you are admitted to the hospital.

Precertification: Non-emergency hospital admissions, diagnostic X-rays and certain other medical services require precertification. Failure to comply with precertification requirements may result in a reduction of benefits.

Out-of-network: Some services are not covered out-of-network.

For more information, please call GHI from 9 am to 5 pm, Monday through Friday, at 212.501.4444. If you have a hearing or speech impairment and use a TDD, call toll-free at 1.866.248.0640.

Prescription Drugs

The DC 37 Health & Security Plan provides prescription drug benefits.

Cost

There is no cost for this program.

For More Information

For additional information, please call (212) 501-4444 and identify yourself as a DC 37 member.

DC 37
125 Barclay Street,
3rd Floor
New York, NY 10007

www.ghi.com



GHI-Comprehensive Benefits Plan (GHI-CBP)

Optional Rider

Prescription Drugs

Retail pharmacy up to a 30-day supply (2 fills) subject to deductible of \$150 per ind./\$450 per family. After deductible, you pay: Generic - 20% coinsurance with a min. charge of \$5 or actual cost if less; Brand-Name Formulary - 40% coinsurance with min. charge of \$25 or actual cost if less; Brand-Name Non-Formulary - 50% coinsurance with min. charge of \$40 or actual cost if less. If you choose a formulary or non-formulary brand that has a generic equivalent, you will pay the difference in cost between the drug and the generic coinsurance.

Mandatory Maintenance Mail Order

Up to a 60-day supply. You pay: \$10 Generic/\$40 Brand-Name Formulary/\$60 Brand-Name Non-Formulary. You must use Mail Service for maintenance medications. Prescriptions will not be filled at retail after two (2) fills.

Prior Authorization is required for certain brand-name medications.

Step-therapy Prescription Program encourages use of best medications for your condition.

Over-the-Counter Equivalent Program (OTC)

Prescription Medications that have an OTC equivalent will not be covered.

With GHI-CBP, you have the freedom to choose any provider worldwide. You can select a GHI participating provider and not pay any deductibles or coinsurance, or go out-of-network and still receive coverage, subject to deductibles and coinsurance.

GHI's provider network includes all medical specialties. When you need specialty care, you select the specialist and make the appointment. Payment for services will be made directly to the provider - you will not have to file a claim form when you use a GHI participating provider.

Participating Provider Benefits -- There is a \$15 copayment per visit to GHI participating medical providers/practitioners and participating mental health care providers. These include practices such as Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, and providers such as Allergists, Cardiologists, Chiropractors and Gastroenterologists (a full list is available on www.emblemhealth.com).

There is a \$20 copayment per visit for GHI participating Surgeons, all Surgical Subspecialties, and Dermatologists. Examples of these providers are those who practice: Cardiothoracic and Thoracic Surgery; Colon and Rectal Surgery; General Surgery; Neurological Surgery; Ophthalmology; Oral Surgery; Orthopedics, and many others (a full list is available on www.emblemhealth.com).

Home Care Services -- These services include intermittent home care services, home infusion therapy, private duty nursing and durable medical equipment. Benefits are paid in full when precertified by the GHI Managed Care Department. Contact GHI Coordinated Care at (212) 615-4662 in New York City, or 800-223-9870 outside New York City. Durable medical equipment is subject to an annual \$100 per person deductible. Coverage for home infusion therapy is available only through GHI participating providers, but all other services can be obtained through non-participating providers, subject to separate annual deductibles and coinsurance.

Mental Health and Chemical Dependency Program -- This plan offers both inpatient and outpatient chemical dependency and mental health benefits. You can choose from over 8,000 psychiatrists, psychologists, social workers and other providers in the metropolitan New York City area who comprise the GHI Behavioral Management provider network. Out-of-network benefits are also available. Complete details on this program are available by calling GHI at 800-NYC-CITY (800-692-2489).

Centers of Specialized Care -- This network of specialty hospitals offers focused expertise in cardiac care and certain transplant procedures. These services are paid in full, without deductibles or coinsurance, when provided at a Center of Specialized Care hospital. Details are available by calling GHI at 800-223-9870 or 212-615-4662.

Non-Participating Provider Benefits -- When you do not use the services of a participating provider, GHI provides coverage for the services of non-participating providers. Payment for these services is made directly to you under the NYC Non-Participating Provider Schedule of Allowable Charges (Schedule). The rate at which you will be reimbursed for a particular service is contained within the Schedule. These reimbursement rates were originally based on 1983 procedure allowances, and some have been increased periodically. The reimbursement levels, as provided by the Schedule, may be less than the fee charged by the non-participating provider. Please note that certain non-participating provider reimbursement levels may be increased if you have the optional rider. The subscriber is responsible for any difference between the fee charged and the reimbursement, as provided by the Schedule. A copy of the Schedule is available for inspection at GHI.

Non-participating provider reimbursement is subject to calendar year deductibles (\$200 per person, up to a maximum of \$500 per family) and a lifetime maximum of \$2 million per person.

Catastrophic Coverage -- If you choose non-participating providers for predominantly in-hospital care and incur \$1,500 or more in covered expenses you are eligible for additional "Catastrophic Coverage". Under this coverage, GHI pays 100% of the Catastrophic Allowed Charge as determined by GHI.

Optional Rider (continued)

- Enhanced schedule for certain services increases the reimbursement of the basic program's non-participating provider fee schedule, on average, by 75%.
- Additional outpatient psychiatric and inpatient chemical dependency treatment services. Call 800-NYC-City (800-692-2489) for details about this benefit.

For More Information

You may contact:
Group Health Incorporated
441 Ninth Avenue
New York, NY 10001
(212) 501-4444

Empire BlueCross BlueShield Hospital Plan

For More Information

To keep you informed about the Empire BlueCross BlueShield Hospital Plan, Empire has staffed the Dedicated Service Center with customer service representatives specially trained to explain the program.

If you would like additional information about Empire's Hospital Plan, please call (800) 433-9592. The Center telephone hours are from 8:30 A.M. to 5:30 P.M., Monday through Friday.

You may write the plan at:

Empire BlueCross
BlueShield
City of New York
Dedicated Service
Center
P.O. Box 1407
Church Street Station
N.Y., NY 10008-3598

www.empireblue.com/nyc

Effective January 1, 2010, the Empire BlueCross BlueShield Hospital Plan (offering benefits for services provided at hospital and out-patient facilities) of the GHI/Comprehensive Benefits Plan will change to Preferred Provider Organization (PPO) coverage for members, retirees and their dependents. A PPO plan provides coverage for both in-network and out-of-network facility services. However, by using a PPO network facility, you will save money. Because 94% of the nation's hospitals participate in the Blue Cross and Blue Shield Association BlueCard® PPO Program network, which provides you with access to network care across the county, it should be easy to find a participating facility in a convenient location.

Inpatient Care: If you use an in-network hospital, you will pay a \$300 inpatient deductible per person per admission, up to a maximum of \$750 in a calendar year. If you use an out-of-network hospital, you will be responsible for a \$500 deductible per person per admission/visit up to a maximum of \$1,250 in a calendar year. After the deductible is met, Empire will pay 80% of the average county rate and you will be charged 20% coinsurance for out-of-network services. In addition, the facility can bill you the difference between their total bill and the amount that they have received from both Empire and you; this is called balance billing.

Ambulatory Surgery: If surgery or procedures (such as chemotherapy, blood transfusions and pre-surgical testing) are done in-network at a participating ambulatory surgery center or hospital outpatient surgery department, free standing ambulatory surgery center or the outpatient department of a participating hospital, you will be responsible for 20% coinsurance up to a maximum of \$200 per person per calendar year. If you choose to use an out-of-network facility, you may have significant out-of-pocket expenses. Depending on the procedure, this can amount to several thousand dollars or more instead of the maximum \$200 coinsurance that applies when you use an in-network facility. If you receive care at an out-of-network facility, you will be responsible for a \$500 deductible per person per admission/visit up to a maximum of \$1,250 in a calendar year. After the deductible is met, Empire will pay 80% of the average county rate and you will pay 20% coinsurance. In addition, the facility can bill you the difference between their total bill and the amount that they have received from both Empire and you; this is called balance billing.

Emergency Care: There is a \$50 co-payment for emergency room care such as treatment for sudden and serious illness and accidental injury treatment. This co-payment is waived if the patient is admitted to the same hospital. Coverage is provided for emergency room physicians and non-invasive cardiology, radiology and pathology services when provided in an emergency. Charges for specialty doctors and/or medical follow-up care related to the emergency should be submitted to GHI, as your medical carrier.

Skilled Nursing Facility Care: Up to 90 days of skilled nursing facility care is available, which may include 30 inpatient days in a rehabilitation hospital primarily for physical therapy, physical rehabilitation or physical medicine. Benefits are subject to NYC Healthline authorization and approval. You will receive full benefits if you receive covered services at an in-network skilled nursing facility. If you receive care at an out-of-network facility, you will be responsible for a \$500 deductible per person per admission/visit up to a maximum of \$1,250 in a calendar year. After the deductible is met, Empire will pay 80% of the average county rate and you will pay 20% coinsurance. In addition, the facility can bill you the difference between their total bill and the amount that they have received from both Empire and you; this is called balance billing.

Hospice Care: The Hospital Plan also offers coverage for hospice care for up to 210 days. Full benefits for this service are provided when they are rendered in a licensed Hospice Facility.

Worldwide Protection: If you travel abroad and need emergency inpatient or emergency outpatient care you will receive in-network coverage (subject to in-network deductible, coinsurance or copay) as long as you are admitted to a general hospital.

Hospital Pre-Admission and Medical Care Requirements

***Enrollees must call NYC Healthline at 800-521-9574 prior to any scheduled hospital admission or within 48 hours of an emergency admission. Failure to call NYC Healthline may result in a penalty of up to \$500.**

Empire EPO

Prescription Drugs

A prescription drug rider offers drug coverage and access to an extensive retail network of approximately 62,000 participating pharmacies, including most major chains as well as many independent neighborhood pharmacies.

There is a \$10 co-payment for generic drugs Tier 1, \$25 co-payment for Tier 2 brand drugs on the formulary list and \$50 co-payment for Tier 3 drugs not on the formulary list. After Empire has covered \$3,000 in drug expenses each year, additional covered prescription drugs are subject to 50% coinsurance for the remainder of the benefit year. For additional information call 1-800-767-8672, 8:30 a.m. to 5:00 p.m., Monday through Friday. You may also contact Empire at:
 Empire BlueCross
 BlueShield
 City of New York
 Dedicated Service Center
 P.O. Box 1407
 Church Street Station
 N.Y., NY 10008

For More Information

For additional information call
 1-800-767-8672,
 8:30 a.m. to 5:00 p.m.,
 Monday through Friday.

You may also contact Empire at:
 Empire BlueCross
 BlueShield
 City of New York Dedicated Service Center
 P.O. Box 1407
 Church Street Station
 N.Y., NY 10008

Empire's EPO, an Exclusive Provider Organization, provides all active and non-Medicare retirees nationally a health plan choice where they live, work, study (for eligible dependent students) or, in some cases, where they travel. Empire's EPO provides access to the Blue Cross and Blue Shield AssociationTM BlueCard[®] PPO Network. This network is very large with more than 784,000 provider locations and more than 5,800 hospitals nationwide¹. That's more than 94 percent of hospitals and 84 percent of physicians in the nation.² plus, you do not need to choose a primary care physician and there are NO REFERRALS NECESSARY to see a specialist for covered services and no claim forms to complete. See your policy for a complete description of how to receive care through the Blue Card Programs and cost share details.

Inpatient hospital care is covered in full when arranged for and authorized by Empire's Medical Management Program with a \$250 co-payment per individual, and a maximum of \$625 co-payment per family per admission. Office visits for medically necessary covered services are subject to a \$15 co-payment. Other benefits include office, specialist and chiropractic visits, allergy testing, diabetes supplies, diabetes education and management, physical therapy, physical rehabilitation, occupational, speech and vision therapy, one annual physical examination, well-woman care, skilled nursing facility care, hospice care, home health care visits including home infusion, durable medical equipment, X-rays, MRI, lab tests, chemotherapy, radiation therapy, diagnostic screening tests, pap smears, mammography, maternity and related maternity care, and well-child care including immunizations visits. Consult your policy for full details regarding all covered benefits, applicable cost shares and age and frequency limits that may apply. There is a \$35 co-payment when you visit the emergency room, which is waived if admitted within 24 hours.

360° Health Empire's Health Services Program is a comprehensive suite of preventive care programs, wellness information, case management and care coordination services, all integrated with the goal of achieving optimal health outcomes for our members.

24/7 NurseLine gives members access to health care information through a toll-free, confidential phone service. Specially trained registered nurses are on hand 24 hours a day, 7 days a week, to help with your routine medical questions and concerns. Members have access to an audio library of more than 1,100 health care topics in English and Spanish.

Anthem Care Comparison allows you to evaluate hospitals based on key quality indicators, and estimate the costs of specific health care services and procedures.

MyHealth Record allows you to build a secure online health profile so all your important medical information is in one place, available to you at any time. You start by adding your own information. Then your record is automatically updated as you use health services and your claims are paid. You can consolidate your health history in one secure location; track doctor visits, vaccinations- a great help if you see multiple doctors. You can also help avoid potentially dangerous drug interactions, medicines you're allergic to or duplicative tests and procedures.

MyHealth helps you find tools and information to help you better evaluate and manage your health. You can get information about chronic and acute conditions through Condition Centers R, find prevention information; learn about pregnancy and the health of children ages six and younger; search a medical dictionary with more than 57,000 entries and access online communities with over 30 health and wellness topics.

MyHealth Assessment helps you pinpoint your personal health risks through a secure online health analysis. Taking it a step further, you'll get a personalized report with action steps designed to help you manage, reduce or eliminate those risks. Plus, MyHealth Assessment automatically populates MyHealth Record. You can easily follow your progress as you make recommended lifestyle changes.

Staying Healthy Reminders- Reminders are sent several times a year to encourage scheduling of important appointments, like a checkup, immunizations or screenings.

SpecialOffers lists discounts available to you for healthy living products and services, like fitness club memberships

Updated to reflect benefit changes effective January 1, 2010.

HIP Prime® POS

HIP Prime® POS is a point-of-service plan offering both in- and out-of-network coverage. Members can go to virtually any doctor or specialist at any location and still take advantage of HIP's value. Non-referred and out-of-network services are subject to deductibles and coinsurance.

Prescription Drugs

A rider is available for HIP Prime™ POS members prescription drug coverage which can be filled at any of HIP's participating pharmacies. At retail: \$10 copay for generic drugs and \$35 copay for brand drugs (up to a 30 day supply); At Mail Order: \$15 copay for generic drugs and \$52.50 for Name Brand drugs (up to a for 90 day supply).

For More Information

To learn more please write to:

HIP
55 Water Street
New York, NY 10041

Or call
1-800-HIP-NYC9
(1-800-447-6929)

Representatives will be available Monday through Friday, 8:00 a.m. to 6:00 p.m. to answer your questions.

You can also request an updated participating physician directory or log on to www.emblemhealth.com now available in English, Spanish, Chinese and Korean.

In-Network Benefits – In-network, you and your family receive comprehensive hospital and medical benefits from HIP participating providers. HIP's New York service area includes the five boroughs of New York City as well as Nassau, Suffolk, Westchester and Rockland Counties. HIP's participating network now numbers over 29,000 participating providers in more than 33,000 service locations. Members have access to top quality health care providers through HIP's alliances with outstanding medical groups and hospitals, including Montefiore Medical Center, Lenox Hill Hospital, St. Barnabas Hospital, St. Luke's Roosevelt Hospital and Beth Israel Medical Center.

You and each family member choose a PCP practicing in a private office or in any of HIP's convenient neighborhood health care centers. You may visit your PCP as often as necessary. Your PCP coordinates your care and works with specialists from virtually every area of medical practice to provide you with the health care you need. Primary Care Physician office visits are subject to a \$5 copayment and Specialists visits are subject to \$10 copayment. Preventive Care visits will remain at \$0 cost to the member.

As a HIP Prime POS member, you and your dependents will be covered for a broad range of in-network hospital and medical services that include routine examinations, medical screenings, X-rays, mammography services, inpatient hospital rehabilitation and skilled nursing facility care, outpatient rehabilitation (physical therapy, occupational therapy, speech therapy) dialysis, home care, well-child care, urgent care, mental health services and a preventive dental program. Emergency Room visits are subject to a \$50 copayment and Hospital Inpatient admission is subject to a \$100 copayment.

Emergency Care

HIP provides coverage for emergency services around-the-clock, whenever and wherever needed. If you experience a medical emergency when traveling outside of the HIP service area – anywhere in the world – you are covered for hospital and medical care. Simply obtain the care you need and notify HIP with 48 hours.

Out-of-Network Benefits

HIP Prime POS offers you the freedom to choose medical and hospital care outside the HIP network. If you choose to bypass your PCP and receive non-referred care or use a physician not affiliated with HIP, you are reimbursed after the deductible for up to 80% of HIP customary charges. Your hospital stay is covered for up to 80% of HIP customary charges as long as it is approved in advance by HIP. Routine preventive care such as periodic health exams, routine immunizations and eye exams are covered only when provided by a participating provider. Routine pediatric and well-child care is covered up to 80% of HIP customary charges. For maternity care, newborn nursing services and mother's hospital services are covered in full in- and out-of-network.

Following an annual deductible of \$250 per individual or \$500 per family, members receive 80% reimbursement of HIP customary charges. You must pay any charges that exceed HIP customary charges. When the 20% coinsurance reaches \$2,000 per individual or \$4,000 per family in a calendar year, HIP Prime POS pays 100% of customary charges for the remainder of the calendar year. You must first contact the HIP Member Advocacy Program to obtain prior approval for services such as hospital and skilled nursing facility care, ambulatory surgery, home care, MRI's, CAT Scans and outpatient alcohol and substance abuse treatment (see your Evidence of Coverage for details and a complete listing of services requiring HIP's prior approval). Failure to obtain prior approval will result in a 50% penalty.

II.

Health Maintenance Organizations (HMOs) (For Employees and Non-Medicare Retirees and their dependents)

A Health Maintenance Organization (HMO) is a system of health care that provides managed, pre-paid hospital and medical services to its members. An HMO member chooses a Primary Care Physician (PCP) from within the HMO network, and the PCP manages all medical services, provides referrals, and is responsible for non-emergency admissions. Individuals and/or families who choose to join an HMO can receive health care at little or no out-of-pocket cost, provided they use the HMO's doctors and facilities. Because the HMO provides all necessary services, there are usually no deductibles to meet or claim forms to file. In most plans, if a physician outside of the health plan is used without a referral from the PCP, the patient is responsible for all bills incurred.

The following Health Maintenance Organizations are offered by the Health Benefits Program

| Health Plan | Phone Number | Web Address |
|--|---------------------|--|
| Aetna HMO | (800) 445-8742 | www.aetna.com |
| CIGNA HealthCare | (800) 832-3211 | www.cigna.com |
| Empire HMO | (800) 767-8672 | www.empireblue.com/nyc |
| GHI HMO | (877) 244-4466 | www.ghihmo.com |
| HIP PRIME HMO | (800) 447-6929 | www.hipusa.com |
| MetroPlus Gold (HHC employees only) | (800) 475-3795 | www.metroplus.org |
| Vytra Health Plans | (800) 448-2527 | www.vytra.com |

Special Notes for Medicare-Eligible Retirees

If a Medicare-eligible retiree is enrolled in a Medicare HMO and has non-Medicare eligible dependents, the corresponding HMOs on pages 30 through 37 provide benefits for those dependents. For information about Medicare enrollee coverage, please refer to the health plans on pages 42 through 48.



Aetna HMO

Aetna is available to City of New York employees and non-Medicare retirees residing in the New York City region (the five boroughs and following counties: Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester) the entire states of New Jersey, Connecticut, and Delaware; and a number of counties in Georgia, Maryland, Massachusetts, North Carolina, Pennsylvania, and Washington D.C.

Prescription Drugs

An optional Rider benefit is available for prescription drug coverage with a three tier structure: \$10 copay for generic drugs/30% coinsurance for formulary drugs/50% coinsurance for non-formulary drug up to a 30-day supply. Mail order: \$20 copay for generic/30% coinsurance for formulary/50% coinsurance for non-formulary up to a 90-day supply. Maximum out-of-pocket expenses of \$3,000 individual/\$9,000 family. Once maximum is met there are no copays or coinsurance.

For More Information

For more details, refer to the City of New York/Aetna Commercial packet. To speak to a customer service representative, call 1-800-445-8742, 8:00 a.m. - 6:00 p.m., Monday through Friday. You can send your questions in writing to:
Aetna
100 Park Avenue -
12th Floor
New York, New York
10017
Attn: City of New York Department

Each Aetna member selects a participating primary care physician to coordinate his/her care and issue specialist and hospital referrals. Primary Care Office visits have a \$15 copay, Specialists have a \$20 copay, and any preventative care is covered at 100%, no copay. There are no deductibles to pay. Hospital has a copayment of \$300 per admission. Ambulatory Services are covered at a \$75 copay. There is a Emergency Room copay of \$75.

Additionally, members have access to:

Aetna Navigator™, Aetna's member website that provides a single source for online health and benefits information 24 hours a day, 7 days a week at www.aetna.com. Through Aetna Navigator, members can change their primary care physician, replace an ID card, research Aetna's products and programs, contact Aetna directly and access a vast amount of health and wellness information. Aetna Navigator also includes secure, personalized features for members who register on the site including access to claim and benefit status. Additionally, members can contact their designated member services team and customize their home page to meet their individual health needs.

DocFind®, an online provider list located at www.aetna.com; **InteliHealth®**, an online consumer health information network located at www.intelihealth.com; and **Informed Health® Line**, a telephonic nurse line available 24 hours a day, 7 days a week.

Aetna Special Medical Programs

Disease Management -- Specific programs are aimed at slowing or avoiding complications of certain diseases through early detection and treatment to help improve outcomes and quality of life. The programs include: Low Back Pain, Asthma, Heart Failure and Diabetes.

The Moms-to-Babies™ Maternity Management Program -- A management program to help identify at-risk pregnancies, which are given special attention from nurse case managers.

Natural Alternatives -- A discount program that offers contracted discounted rates for alternative types of health care (e.g., chiropractors [for chiropractic care not covered under the medical plan], acupuncturists, massage therapists and nutritional counselors), all available without a referral or precertification.

Vision One® Discount Program -- A program that offers significant discounts on eye care needs, such as prescription eyeglasses, contact lenses, non-prescription sunglasses, contact lens solutions and eye care accessories. Members can call 1-800-793-8618 to find the Vision One® locations nearest to them. This benefit is in addition to, not in place of, members' union welfare fund vision benefits.



CIGNA HealthCare

CIGNA HealthCare provides comprehensive health care coverage to NYC employees and non-Medicare eligible retirees living in New York, New Jersey, Connecticut, Los Angeles, CA, and Phoenix, AZ.

Prescription Drugs

CIGNA HealthCare offers an Optional Rider for prescription drug coverage. Retail copays are: \$5 for generic, \$20 for preferred brand-name and \$50 for non-preferred brand-name drugs per prescription (up to a 30 day supply) at participating pharmacies. Mail order copays are: \$10 for generic, \$40 for preferred brand-name and \$100 for non-preferred brand-name (up to a 90-day supply). Generic substitution is required if a Federal Drug Administration (FDA) approved generic exists. You can see CIGNA's list of covered drugs on www.cigna.com.

For More Information

For answers to your questions, call toll-free (800) 564-7642. If you are already a member call 800-CIGNA24. Representatives are available to answer your questions. In New York City you can write to:

CIGNA HealthCare
Attn: Dan Moskowitz
499 Washington Blvd
4th Floor
Jersey City, NJ 07405

With the CIGNA HealthCare Open Access Plus In-Network plan you may visit any doctor who participates in the CIGNA HealthCare Open Access Plus network. CIGNA's group of highly qualified doctors who meet our standards of care is one of the largest in the New York and New Jersey area with over 30,000 personal doctors and over 115,000 specialists.

You're free to choose your own doctors, and each member of your family can elect his or her own Primary Care Physician from our network. You won't need referrals to see specialists, and quality care is close by at home. If you are traveling on business or vacationing, you have access to our Open Access Plus network that has over 645,000 physicians nationwide. In an emergency, your plan covers your care, 24 hours a day. You are responsible for a \$15 copayment for Primary Care Physician office visits, a \$25 copayment for each specialist office visit, and a \$150 copayment for every hospital admission.

Health and Wellness Programs

CIGNA's commitment to wellness emphasizes prevention and staying well. CIGNA's plans offer comprehensive preventive care and health education programs such as health screenings, including mammography and cholesterol screenings. Through our local and national wellness programs, you receive information and support that help you stay fit and enjoy a healthier life.

CIGNA HealthCare Well Aware® Program for Better Health is a comprehensive program directed toward individuals with chronic illnesses such as Asthma, Heart Disease, Chronic Obstructive Pulmonary Disease (COPD), Low Back Pain, Diabetes, Weight Complications, Targeted Conditions and Depression Management.

The Child Health Immunization Program covers important baby and child immunizations. CIGNA encourages you to take advantage of these important wellness programs by sending you and your dependents annual birthday card reminders.

CIGNA's Healthy Babies Program provides free educational materials about pregnancy and babies, including information from the March of Dimes®. We also provide round-the-clock access to a toll-free information line staffed by experienced registered nurses.

The Healthy Woman's Program covers annual pap tests, mammograms as needed, and access to OB/GYNs without a referral from a personal doctor.

CIGNA LIFESOURCE Transplant Network® gives you access to independent transplant centers that are nationally recognized for their quality care for organ and tissue transplantation.

CIGNA HealthCare 24-Hour Health Information LineSM offers the services of trained Registered Nurses who are on call and on duty around the clock, seven days a week. They can answer specific questions on health issues, provide general health information and can help assess emerging symptoms and recommend appropriate settings for care. The CIGNA HealthCare 24-Hour Health Information Line also includes an audio library that you can access any time. The library provides confidential pre-recorded general information on hundreds of health and medical topics. If you have a specific question, you can opt out at any time and speak directly with a nurse.

CIGNA Healthy Rewards® Program expands your health care options giving you access to health and wellness programs not covered by many traditional benefits plans. At the same time, you save money through discounts on Weight Watchers®, acupuncture, chiropractic care, therapeutic massage, laser vision correction, smoking cessation and more. CIGNA also participates in the Global Fit Network, which offers discounted access to health and fitness clubs across the tri-state region.

Empire HMO

Prescription Drugs

A prescription drug rider offers access to over 4,200 pharmacy network providers in the New York tri-state area, and over 54,000 network pharmacies nationwide. There is a \$10 copayment for generic drugs, \$25 copayment for brand drugs on the formulary list and \$50 copayment for drugs not on the formulary list. After Empire Pharmacy Management has paid \$3,000 in drug expenses, all drugs have a 50% coinsurance for each benefit year.

For More Information

Please call 1- 800-767-8672, 8:30 a.m. to 5:00 p.m., Monday through Friday.

You may contact contact the plan at:

Empire BlueCross
BlueShield
City of New York
Dedicated Service
Center
PO Box 1407
Church Street Station

Empire HMO, is available to New York State residents who live or work in our 28-county NY service area, the 8 bordering New Jersey counties of Essex, Hudson, Union, Sussex, Passaic, Monmouth, Middlesex, and Bergen, and the 2 bordering Connecticut counties of Fairfield and Litchfield, lets you choose from over 66,000 providers and 200 hospitals in our local service area.

This program features a full range of in-network benefits with low out-of-pocket costs, no claim forms, and access to quality health care for you and your family. With Empire's HMO, every family member can choose his or her own Primary Care Physician (PCP). The PCP must participate in Empire's HMO network and may be selected in any of the following areas of specialization: internists, family practitioners, general practitioners, pediatricians or ob/gyn. Your PCP helps manage your care by making the necessary referrals to specialists in the network.

Inpatient hospital care is covered in full when medically necessary and arranged for and authorized by your PCP, except for a \$250 co-payment per individual, with a maximum of \$625 co-payment per family. Per admission Office visits for covered services are subject to a \$15 co-payment. Other benefits include: Office, specialist, and chiropractic visits; Allergy testing; Diabetes supplies, education, and management; Physical therapy and rehabilitation; Occupational, speech, and vision therapy; One annual physical examination; Well-woman care; Skilled nursing facility; Hospice care; Home health care visits, including home infusion; Durable medical equipment; X-rays, MRI, and lab tests; Chemotherapy and radiation therapy; Diagnostic screening tests; Pap smears and mammography; Maternity and related maternity care; Well child care, including immunizations visits. Consult your policy for full details regarding all covered benefits, applicable cost shares and age and frequency limits that may apply.

Urgent & emergency cares are available to members and their eligible dependents nationwide through the BlueCross BlueShield AssociationTM BlueCard[®] Program's provider network. There is a \$35 co-payment for visits to the emergency room in an emergency, which is waived if admitted within 24 hours. HMO Guest membership is available for you and/or your eligible dependents if you are temporarily living away from your home HMO service area for at least 90 days.

360° Health Empire's Health Services Program is a comprehensive suite of preventive care programs, wellness information, case management and care coordination services, all integrated with the goal of achieving optimal health outcomes for our members.

24/7 NurseLine gives members access to health care information through a toll-free, confidential phone service. Specially trained registered nurses are on hand 24 hours a day, 7 days a week, to help with your routine medical questions and concerns. Members have access to an audio library of more than 1,100 health care topics in English and Spanish.

Anthem Care Comparison- Allows you to evaluate hospitals based on key quality indicators, and estimate the costs of specific health care services and procedures.

MyHealth Record – Allows you to build a secure, online health profile so all your important medical information is in one place, available to you at any time. You start by adding your own information. Then your record is automatically updated as you use health services and your claims are paid. You can consolidate your health history in one secure location; track doctor visits, vaccinations- a great help if you see multiple doctors. You can also avoid potentially dangerous drug interactions, medicines you're allergic to or duplicative tests and procedures.

MyHealth@Empire- Helps you find tools and information to help you better evaluate and manage your health online 24/7 at empireblue.com. You can manage chronic and acute conditions through Condition Centers R, find prevention information; monitor a pregnancy and the health of children ages six and younger; search a medical dictionary and access the online communities with over 30 health and wellness topics.

MyHealth Assessment- Helps you pinpoint your personal health risks through a secure online health analysis. Taking it a step further, you'll get a personalized report with action steps designed to help you manage, reduce or eliminate those risks. Plus, MyHealth Assessment automatically populates MyHealth Record. You can easily follow your progress as you make recommended lifestyle changes.

Staying Healthy Reminders- Reminders are sent several times a year to encourage scheduling of important appointments, like a checkup, immunizations or screenings.

SpecialOffers - Lists discounts available to you for healthy living products and services, like fitness club memberships.

GHI HMO

This plan is open to employees and retirees residing in the counties of Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, and Westchester in New York.

Prescription Drugs

GHI HMO offers an optional rider for prescription drug coverage. Retail copayments are: \$8 generic; \$16 preferred brand and \$30 non-preferred brand per prescription at participating pharmacies. Mail order (up to 90-day supply) copayments are: \$16 generic; \$32 preferred brand and \$50 non-preferred brand. Prescriptions are dispensed on a generic basis. Members requesting a brand name drug must pay the difference between the brand name drug and the generic drug when a generic drug is available, plus the generic copayment.

GHI HMO is a Health Maintenance Organization (HMO), offering its members the opportunity to receive health care services at a participating physician's private office. Each GHI HMO member selects his or her own Primary Care Physician (PCP). Physician office visits require a \$15 copayment.

As a GHI HMO member, you and each member of your family will choose a PCP from GHI HMO's list of participating providers. For adults, the PCP will specialize in either internal medicine or family practice and, for children, specialization will be in either pediatrics or family practice. Your PCP will coordinate all health care services, including referrals, which must be arranged for and authorized by your PCP.

GHI HMO members receive full coverage for inpatient hospital care when arranged for and authorized by their PCP. Most inpatient care will be provided at a participating hospital where your PCP or Specialist has admitting privileges, including all participating hospitals in the GHI HMO service area. Specialized care not available in local participating hospitals may be referred to GHI HMO's tertiary medical centers. In addition, medically necessary services not provided by GHI HMO participating hospitals or affiliated providers will be arranged by your PCP and covered in full. There is \$0 copay for inpatient stays and \$0 copay for ambulatory surgical procedures when performed by a participating physician in a participating hospital.

Comprehensive Coverage

GHI HMO coverage is comprehensive. Routine health care, office visits, allergy tests and treatment, eye and ear exams, laboratory services, X-rays, diagnostic tests, second surgical opinions, health education, well-baby and well-child care, prenatal and post-natal care, services of a physician, surgeon, anesthesiologist, emergency services, skilled nursing care, mental health care, physical therapy and rehabilitation, chiropractic services and acupuncture are all covered.

Emergency Care

Emergency care is covered, provided that the services are authorized by your GHI HMO PCP. For life-threatening emergencies, members receive immediate care and then are expected to call their GHI HMO PCP within 48 hours of receiving care. Members are covered 24 hours per day/7 days per week. Emergency care is covered anywhere in the world. There is a \$35 copayment for each emergency room visit that does not result in an admission.

For More Information

Contact GHI HMO at:
(877) 244-4466 or (877) 208-7920 (TDD only).

You can also send your questions in writing to:
GHI HMO
P.O. Box 4181
Kingston, NY 12402
Attn: Customer Service

HIP Prime HMO

HIP Health Plan of New York was created more than 57 years ago to provide city workers and union members with high quality, affordable health insurance. Today, HIP remains committed to offering city employees and retirees a full range of coverage for medical and hospital services.

Optional Rider Benefits

A rider is available that offers HIP Prime HMO members prescription drug coverage which can be filled at any of HIP's participating pharmacies. There is \$5 copay for generic drugs and \$15 copay for formulary drugs at retail and 2X copay at mail order.

You can also choose a rider for durable medical equipment and in-hospital private duty nursing.

HIP's network has grown to over 22,000 participating providers in more than 33,000 service locations, including thousands of private practice offices and convenient neighborhood health care centers. Members have access to top quality health care providers through HIP's alliances with outstanding medical groups and hospitals, including Montefiore Medical Center, Lenox Hill Hospital, St. Barnabas Hospital, St. Luke's Roosevelt Hospital and Beth Israel Medical Center.

HIP Prime HMO offers members choice, convenience and access to quality health care. You and each member of your family choose a primary care physician (PCP) practicing in his/her private or group office or at any of the health care centers throughout HIP's service area. HIP's service area includes the five boroughs of New York City as well as Nassau, Suffolk, Westchester and , Rockland counties.

You can choose a different PCP for each family member. You may visit your PCP as often as necessary without charge. Simply call for an appointment. Whether it is a routine physical or a specific medical treatment, your PCP coordinates your care and works with specialists from virtually every area of medical practice to provide you with the health care you need.

As a HIP Prime member, you and your dependents will be covered for a broad range of hospital and medical services that include routine examinations, medical screenings, X-rays, mammography services, inpatient hospital rehabilitation and skilled nursing facility care, outpatient rehabilitation (physical therapy, occupational therapy, speech therapy), dialysis, home care, well-child care, urgent care, mental health services and a preventive dental program. There is a \$50 copay for ambulatory surgery and a \$100 copayment for an inpatient admission.

Emergency Care

HIP provides coverage for emergency services around-the-clock, whenever and wherever needed subject to a \$50 copay for emergency room visit (waived if admitted). If you experience a medical emergency when traveling outside of the HIP service area – anywhere in the world – you are covered for hospital and medical care. Simply obtain the care you need and notify HIP within 48 hours.

Staying Healthy

Special programs focus on the importance of a healthy life-style and preventive health care. HIP offers programs to help you lose weight, stop smoking, reduce stress and exercise regularly. HIP will also help you learn how to prevent illness and manage chronic conditions such as diabetes, heart disease and asthma.

Value Added Programs

Members also have access to value added programs at discounted rates, including laser vision correction, an alternative medicine program, preventive dental services and fitness club memberships. These are not covered benefits, but HIP members have access to a network of providers that offers these services at a discounted rate.

Web Site

Visit HIP's web site at www.hipusa.com. Now available in English, Spanish, Chinese and Korean.

For More Information

To learn more please write to:
HIP
55 Water Street
New York, NY 10041

For further information please call
1-800-HIP-NYC9
(1-800-447-6929).
Representatives will be available Monday through Friday, 8:00 a.m. to 6:00 p.m. to answer your questions. You can also request an updated participating physician directory or log on to www.hipusa.com

MetroPlus Gold

MetroPlus Gold is available at no cost to New York City Health and Hospitals Corporation (HHC) employees, non-Medicare eligible HHC retirees, their spouses or qualified domestic partners, and eligible dependents. MetroPlus Gold is offered by MetroPlus Health Plan, a wholly owned subsidiary of HHC, which has been insuring HHC employees since it was founded in 1985.

Prescription Drugs

MetroPlus Gold members who elect the optional Prescription Drug Rider receive coverage for prescription drugs on the MetroPlus formulary. Members can fill prescriptions at over 1,600 MetroPlus participating pharmacies throughout NYC. There is a \$5 copayment for drugs on the MetroPlus formulary. There are no deductibles.

No Cost: There are no deductibles, copayments, bills or claim forms for covered services when provided by your MetroPlus Primary Care Provider (PCP) or referred by your PCP to a participating provider.

Network: MetroPlus has providers in over 12,000 offices in Manhattan, Brooklyn, Queens and the Bronx. PCPs are located in private doctor's offices, neighborhood family care sites and hospitals. MetroPlus members can receive primary care and specialty services at HHC's eleven hospitals and six Diagnostic & Treatment Centers, as well as from doctors at Lutheran Medical Center, Maimonides Medical Center, Peninsula Hospital and the hospitals of Continuum Health Partners, including Beth Israel Medical Center, St. Luke's/Roosevelt Hospital and Long Island College Hospital. Specialty services are available at Mount Sinai Medical Center in Manhattan, Mount Sinai Hospital of Queens, NYU Medical Center-The Rusk Institute, NYU Medical Center-The Tisch Hospital, SUNY Downstate Medical Center-University Hospital of Brooklyn and New York Eye and Ear Infirmary.

Benefits: MetroPlus Gold members select a MetroPlus PCP who provides routine and preventive care and coordinates all of their health care needs. Members can visit their PCP as often as necessary without charge. Members do not need a referral to see a MetroPlus OB/GYN. If a member needs care that the PCP cannot provide, the PCP will refer the member to a MetroPlus Participating Provider. MetroPlus Gold covers maternity care, well-child care, emergency services, hospital care, mental health services and other medically necessary services in full. If a member needs medical care in the US when they are outside of the MetroPlus service area, MetroPlus covers medically necessary services in full, when authorized by MetroPlus. For detailed information on covered services, refer to the Certificate of Coverage on www.metroplus.org.

For More Information

Contact MetroPlus Customer Services Monday through Saturday, 8 am - 8 pm at 877-475-3795 or go to www.metroplus.org.

Member Services: MetroPlus provides care management programs to help members with chronic conditions stay healthy and provides support to help them manage their illness. MetroPlus Customer Services are available Monday through Saturday, 8 am - 8 pm at 877-475-3795. After business hours, members can call the MetroPlus After Hours Service Line at 800-442-2560.

Enrollment: Employees can enroll when they are hired or during the annual Open Enrollment period. For more information on MetroPlus Gold, contact your HHC Human Resources Department, call MetroPlus at 877-475-3795 or go to www.metroplus.org.



Vytra Health Plans

Vytra Health Plans offers New York City employees and retirees an opportunity to access quality healthcare in Queens, Nassau and Suffolk counties. More than 13,000 private practice physicians and provider locations are available in the tri-county service area. Through a strict credentialing process and an ongoing quality assurance program, Vytra Health Plans ensures that members receive the best medical care available.

Prescription Drugs

Vytra Health Plans offers an optional rider for prescription drug coverage that is accepted at over 90% of the pharmacies in the United States. See the Vytra Health Plans medical directory for a complete listing of tri-county area pharmacies. There is a \$7 copay per prescription (brand and generic) after an annual \$50 per person deductible has been met. There is no annual limit.

At the heart of Vytra's healthcare plan is your Primary Care Physician (PCP). This is a family practitioner or internist or in the case of children, a pediatrician, whom you select from our extensive medical directory. Your PCP coordinates all your healthcare needs. This includes providing routine care, prescribing medication, arranging for referrals to specialists, laboratory testing, X-rays and hospital stays when necessary. When you enroll in Vytra Health Plans, you become a member of a comprehensive health care plan designed to promote good health, as well as the delivery of quality care in times of illness or injury.

Preventive Care - Preventive Care, including physical examinations, is covered through your PCP. You pay \$5 for each visit to your PCP. Well-child visits are also covered through PCPs. No co-payment is required for well-child visits for members from birth through 18 that are scheduled within the standards of the American Academy of Pediatrics.

Emergency Care - Medically necessary emergency care is covered anywhere in the world. You can call Vytra Health Plans for guidance on emergency care 24 hours a day, 7 days a week. There is a \$25 co-pay for medically necessary emergency treatment. This is waived if admitted to the hospital.

Specialty Care - In addition to routine medical care, your PCP helps you get the specialty care you need through a large network of participating providers. When specialty services are necessary, your PCP will refer you to the appropriate specialist. Specialist consultations and treatment, short-term physical, occupational or speech therapy, and allergy testing and treatments are provided at \$5 per visit.

OB/GYN - Female members also have the option to select a participating Vytra Health Plans Obstetrician/Gynecologist (OB/GYN) who provides care within his/her specialty without a referral from the PCP. Routine exams, mammography and Pap tests are covered with a \$5 co-payment. Maternity care - including prenatal visits, delivery, hospital stay and post-natal care - is covered 100%.

Hospital Coverage - Your admission to any of the tri-county hospitals is based upon your participating physician's admitting privileges. You will find this information in the Vytra Health Plans medical directory. Hospital services, including pre-admission testing, unlimited room and board in a semiprivate room, physician services for surgery and anesthesiology, prescribed medications and diagnostic services are covered at 100%.

Skilled nursing facility care for up to 45 days per calendar year is covered at 100%. Mental health and substance abuse services are also offered.

Health Promotion - Vytra's commitment to service is demonstrated in various health and wellness programs designed to make staying well easy and convenient. A quarterly wellness magazine, *Pulse*, provides health, wellness and life-style information, as well as information about your Vytra plan benefits. Wellness Seminars, featuring topic experts, are provided to teach you how to feel well and maintain a healthy life-style. Other health improvement programs include *Healthier Living* care management, *Prime of Our Lives* dedicated to women's health for those over age 45, and *Little Stars* prenatal and pregnancy management program. Vytra's *Healthy Savings* program offers discounts on fitness and health-related services from local Long Island participating businesses. From fitness centers to vision centers, swimming lessons to sailing lessons, over two dozen organizations take part in this discount program.

For More Information

To speak with a New York City Account Representative, call Vytra Health Plans at (631) 694-6565 or (800) 406-0806, Monday through Friday, 8:30 a.m. to 5:30 p.m.

You may contact the health plan at:
Vytra Health Plans
Corporate Center
395 North Service
Road
Melville, New York
11747-3127

www.vytra.com

Important Information About Health Plan Enrollment and Disenrollment

Many Medicare HMOs (even those not participating in the City's program) market directly to Medicare-eligible retirees. Because of certain rules set up by the Federal Government a retiree wishing to enroll in a Medicare HMO must complete a special application directly with the health plan he or she elects to join. For those plans participating in the Health Benefits Program, the procedure is to have the retiree complete the application with the health plan (each enrollee must complete a separate application). The health plan then sends a copy of each application to the Health Benefits Program in order to update the retiree's record to ensure that the correct deductions, if applicable, are taken from the retiree's pension check.

Problems can arise when the retiree does not tell the health plan that he/she is a City of New York retiree, in which case the application is not forwarded to the Health Benefits Program Office. This can cause several problems such as: incorrect pension deductions and insufficient health coverage. Therefore, there are several rules you should follow to ensure that you do not jeopardize your health plan coverage under the Health Benefits Program.

When You Enroll . . .

When you enroll directly with the Medicare HMO make sure that you inform the health plan representative that you are a "City of New York" retiree. If your spouse is also covered by you for health benefits, make sure that he/she also completes an enrollment application. Both the retiree and covered dependent(s) must be enrolled in the same health plan under the City's program. To enroll in a Medicare supplemental plan you must do so through the Health Benefits Program Office.

When You Transfer from a Medicare HMO to a Supplemental Plan . . .

If you disenroll from a Medicare HMO and you wish to transfer to a Medicare supplemental plan, such as GHI/EBCBS Senior Care, you can do so only during the Transfer Period. If you wish to transfer at any other time, unless you are moving out of the health plan's service area or the health plan is closing in your area, you must use your Once-in-a-Lifetime Option. If you wish to transfer to a supplemental plan, you must notify the HMO or the Social Security Administration, in writing, that you no longer wish to participate in that HMO.

When You Transfer from a Medicare HMO to another Medicare HMO . . .

If you wish to disenroll from a Medicare HMO and wish to join another Medicare HMO you can do so by enrolling directly in the new plan. If you wish to disenroll from a Medicare HMO and are not enrolling in another Medicare HMO, you must notify the health plan or the Social Security Administration, in writing, that you no longer wish to participate in that plan. If you do not notify the health plan or the Social Security Administration that you no longer wish to participate you will not have any coverage from either the health plan or from Medicare.

For Prescription Drug Coverage . . .

Medicare-eligible retirees enrolled in these plans will receive enhanced prescription drug coverage from the Medicare HMO (as described in each plan's summary page) if their union welfare fund does not provide prescription drug coverage, or does not provide coverage deemed to be equivalent, as determined by the Health Benefits Program, to the HMO enhanced coverage. The cost of this coverage will be deducted from the retiree's pension check. Some welfare funds may pay the cost of the coverage on behalf of the retiree or reimburse the retiree for all or part of the cost of the coverage. Consult your welfare fund for details.



Health Plans for Medicare-Eligible Retirees and Their Medicare-Eligible Dependents

Medicare Supplemental Plans

The traditional Medicare supplemental plan allows for the use of any provider and reimburses the enrollee who may be subject to Medicare or plan deductibles and coinsurance. The following are supplement plans:

| Health Plan | Phone Number | Web Address |
|---|----------------|--|
| Aetna Medicare Plan (PPO) with an Extended Service Area (ESA) | (800) 445-8742 | www.aetna.com |
| DC 37 Med-Team Senior Care | (212) 501-4444 | www.ghi.com |
| Empire Medicare-Related Coverage | (800) 767-8672 | www.empireblue.com/nyc |
| GHI/EBCBS Senior Care | | |
| GHI: | (212) 501-4444 | www.ghi.com |
| Empire BlueCross BlueShield: | (800) 767-8672 | www.empireblue.com/nyc |

Medicare HMOs

Medicare HMO plans are those in which medical and hospital care is only provided by the HMO. Any services, other than emergency services, that are received outside the HMO, that have not been authorized by the HMO, will not be covered by either the HMO or Medicare. Any cost incurred would be the responsibility of the enrollee. The following plans are approved Medicare HMOs:

Medicare HMOs Available in the New York Metropolitan Area:

| Health Plan | Phone Number | Web Address |
|-------------------------------------|----------------|--|
| Aetna Medicare Plan (HMO) | | |
| Medicare 10 Special | (800) 445-8742 | www.aetna.com |
| Elderplan | (718) 921-7898 | www.elderplan.org |
| Empire MediBlue | (800) 499-9554 | www.empireblue.com/nyc |
| GHI HMO Medicare Senior Supplement | (877) 244-4466 | www.ghi.com |
| HIP VIP Premier | (800) 447-6929 | www.hipusa.com |
| SecureHorizons by UnitedHealth Care | (800) 203-5631 | www.securehorizons.com |

Medicare HMOs Available Outside the New York Metropolitan Area:

| Health Plan | Phone Number | Web Address |
|--|----------------|--|
| AvMed Medicare Plan | (800) 782-8633 | www.avmed.com |
| BlueCross BlueShield of Florida Health Options, Inc. | (800) 876-2227 | |
| CIGNA HealthCare for Seniors | (800) 592-9231 | www.cigna.com |
| GHI HMO Medicare Senior Supplement | (877) 244-4466 | www.ghi.com |
| Humana Gold Plus | (800) 833-1289 | www.humana.com |

Retirees wishing to enroll in a Medicare HMO must complete a special application directly with the health plan he or she elects to join. To enroll the retiree must complete the specific health plan application (each enrollee must complete a separate application) and return it to the health plan. A copy of the application is sent to the Health Benefits Program (HBP) from the health plan in order for HBP to update its files and to make sure that the correct deductions, if applicable, are taken from the retiree's pension check.



Aetna Medicare Plan (PPO) with an Extended Service Area (ESA)

The Aetna Medicare Plan (PPO) with Extended Service Area (ESA) 100 is available to City of New York Medicare beneficiaries residing in CT, DE, GA, MA, MD and NC. All individuals entitled to Part A and enrolled in Medicare Part B, including the disabled, may apply. The Aetna Medicare Plan (PPO) with Extended Service Area (ESA) 100 plan pays at 100% for all covered services.

The Aetna Medicare Plan (PPO) with an Extended Service Area (ESA) offers comprehensive coverage, all in one plan. Everything from routine physicals to preventive care beyond Original Medicare and hospitalization is covered, with the flexibility to visit a doctor or hospital of your choice. If your provider does not participate in the Aetna Medicare network, but is willing to accept your PPO plan and is eligible to receive Medicare payment, you can receive covered services at the same in-network cost sharing amount.

Health and Wellness Discounts

Vision Products- save on eyeglass lenses, frames, contact lenses and LASIK surgery.

Fitness- save on home fitness equipment and membership at more than 1,500 independent health and fitness clubs nationwide through GlobalFit.

Alternative Health Care- enjoy discounts on massage, acupuncture and chiropractic services, as well as vitamins, herbal and nutritional supplements and natural products.

Weight Management- Aetna Weight Management discount program entitles you and eligible family members to discounts on programs and products from Jenny Craig

Health and Wellness Programs

Disease Management Program- specially trained medical professionals will work with you and your health care provider to help you manage one or more chronic conditions.

Cancer Screenings- receive reminders to have regular screenings for breast, colorectal and cervical cancers.

Informed Health Line- speak with a registered nurse, 24/7, on health-related issues; access Aetna's Audio Health Library to learn about various health conditions in English or Spanish.

Healthy Lifestyle Coaching- speak to a licensed professional by phone for everything from weight management to smoking cessation.

National Medical Excellence Program- a registered nurse manager or a case manager will help you manage through a difficult procedure or an unfamiliar health care system while traveling far from home.

Patient Safety through MedQuery Care Considerations- identify potential errors and inconsistencies in care and communicate them to the treating physician, improving quality of care and preventing errors.

Optional Prescription Drug Plan (PDP) Rider

City of New York Retirees eligible for the Aetna Medicare Plan (PPO) with Extended Service Area (ESA) plan have the option of adding a prescription drug plan rider.

Retail: \$0/\$20/\$40 for a 30-day supply.

Mail Order: \$0/\$40/\$80 for 90-day supply.

Copays effective up to \$2,840. Once \$2840 is reached then member pays 50% coinsurance for Generic/Brand drugs up to true-out-of-pocket costs of \$4,550. Once member reaches \$4,550 the copays are the greater of \$2.50 or 5% for covered generic drugs (including brand names treated as generic drugs) or the greater of \$6.30 or 5% for all other covered drugs.

For More Information

For further information
call (800) 445-8742

8:00 a.m. – 6:00 p.m.,
Monday through Friday.

You can send your
questions to:

Aetna
99 Park Avenue
New York, New York
10016

Attn: City of New York

www.aetna.com

Cost

There is no cost for this plan.

For Further Information

For more details about AvMed Medicare Plans, you should call 1-800-782-8633. A qualified Medicare representative will help you with your questions and arrange an appointment with an AvMed Medicare representative to help you fill out your enrollment form. Please identify yourself as a City of New York retiree.

As an AvMed member, you gain access to a state-of-the-art health care system designed to minimize medical costs without sacrificing the quality of care. You are free to choose a doctor from AvMed's extensive list of physicians. Please be aware that in order for you to receive payment on coverage for services, the services you receive must be rendered by physicians, hospitals, and other health care providers designated by AvMed. If the services are rendered by a non-AvMed participating physician, hospital, or other health care provider, you may be liable for payment of such services, except for emergency or out-of-the-area urgently needed care conditions.

As a AvMed member you are also offered additional benefits such as: Dental Plan

Health Management Programs: Disease Management Programs, Medication Therapy Management Program

Dade County:

PCP: \$0

Specialists: \$0 to \$5 copay for each specialist visit for Medicare covered benefits.

Inpatient Hospital: Days 1-5 \$0 copay per day; Days 6-23 \$100 copay per day; Days 24-90 \$0 copay per day

Diagnostic tests, x-rays, lab services and radiology

\$0 Lab services; \$25 copay for Medicare covered x-rays; 20% PET Scans; \$50 copay for Medicare covered therapeutic radiology services; \$100 Complex outpatient diagnostic tests (CT, MRI, MRA and nuclear cardiac imaging studies).

Prescription Drug Coverage for Dade County

Retail: \$0/\$20/\$50/33%

Mail: \$0/\$60/\$150

Copays up to \$4,000 in drug costs. After member reaches \$4,000 – Plan covers all generics through gap. Member pays 50% of cost for Brand name drugs until member's yearly out-of-pocket costs reaches \$4,550. Member then pays the greater of \$2.50 for generic and \$6.30 copay for all other drugs, or 5% coinsurance (whichever is greater).

Broward County:

PCP: \$0

Specialists: \$0 to \$5 copay for each specialist visit for Medicare covered benefits.

Inpatient Hospital: Days 1-5 \$0 copay per day; Days 6-23 \$100 copay per day; Days 24-90 \$0 copay per day.

Diagnostic tests, x-rays, lab services and radiology

\$0 Lab services; \$25 copay for Medicare covered x-ray; 20% PET Scans; \$50 copay for Medicare covered therapeutic radiology services; \$100 Complex outpatient diagnostic tests (CT, MRI, MRA and nuclear cardiac imaging studies).

Prescription Drug Coverage for Broward County

Retail: \$0/\$20/\$50/33%

Mail: \$0/\$60/\$150

Copays up to \$4,000 in drug costs. After member reaches \$4,000 – Plan covers all generics through gap. Member pays 50% of cost for Brand name drugs until member's yearly out-of-pocket costs reaches \$4,550. Member then pays the greater of \$2.50 for generic and \$6.30 copay for all other drugs, or 5% coinsurance (whichever is greater).

Updated to reflect benefits changes effective January 1, 2011.



BlueCross BlueShield of Florida Health Options - Medicare & More (Florida Residents)

Health Options Medicare & More, backed by BlueCross BlueShield of Florida, is a federally-qualified HMO with a Medicare contract, available to New York City retirees who reside in Broward, Dade and Palm Beach counties. Medicare & More provides comprehensive, preventive health care coverage, unlimited hospital and doctor care, home health care, skilled nursing facility care, lab tests, x-rays, periodic health assessments, and prescription drugs.

When you enroll in Medicare & More, you select a Primary Care Physician (PCP) from our contracting network of health care providers. You can be assured that any care you receive is covered if it has been provided or arranged by your PCP and there are virtually no claims to file. The PCP you choose will provide or arrange all of your routine health care, including referrals to Medicare & More specialists, when appropriate, and inpatient care at a Medicare & More hospital or skilled nursing facility, when necessary. Your PCP coordinates your health care to ensure that you get the care that is right for you and to assist you in getting the most from your Medicare & More coverage. Should you need specialty care, your PCP will arrange it for you.

Except for emergencies anywhere and out-of-area urgent care, all care you receive must be obtained from the health care professionals and facilities in the Medicare & More provider network.

Prescription Drug Coverage

Retail \$4.00 generic drugs (31-day supply)

Mail: \$4.00/\$30.00/\$70.00 for 31 days

\$12/\$90/\$210 for 90 days

After yearly out-of-pocket drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550. After member reaches \$4,550 member then pays the greater of \$2.50 and \$6.30 or 5% coinsurance (whichever is greater).

Cost

There is no cost for this plan.

For More Information

Contact the plan at:
BlueCross BlueShield
of Florida, Inc.
Health Options, Inc.
3750 NW 87th Avenue
Suite 300
Miami, FL 33278-2415
(800) 876-2227



CIGNA HealthCare for Seniors

CIGNA HealthCare for Seniors is available to retirees with Parts A and B of Medicare in Phoenix, Arizona (Maricopa and Pinal Counties only).

With the CIGNA HealthCare for Seniors Plan, you are subject to a \$5 copay for PCP visits, \$15 copay for Specialist visits at CIGNA HealthCare Centers; copays vary for visits to other providers contracted by CIGNA. Plus you'll find extras, like annual physicals and worldwide emergency care.

For More Information

**Please call:
CIGNA
Phoenix, AZ
1-800-592-9231**

Little or No Paperwork

CIGNA HealthCare for Seniors virtually eliminates paperwork. Each time you go for a visit, you simply show your CIGNA ID card when using a plan provider.

Prescription Drug Coverage

Retirees who receive prescription drug coverage through their union welfare fund will continue to access that coverage.

Retirees in union welfare funds where prescription drugs are not covered will automatically receive the following prescription drug benefit:

Retail: \$5/\$40/\$65

Mail: \$15/\$120/\$195

Copays up to drug costs of \$2,830, then all Tier I drugs are covered in the Gap. When member reaches \$4,550 member then pays the greater of \$5.50 and \$6.30 or 5% coinsurance (whichever is greater).



DC 37 Med-Team Senior Care

The DC 37 Med-Team Senior Care health insurance plan is offered by GHI to DC 37 Med-Team Medicare-eligible retirees. This plan, which supplements Medicare, has no pension deduction.

DC 37 Med-Team's hospital coverage supplements Medicare Part A to provide benefits for such services as semi-private room and board and general nursing care. The plan's medical coverage supplements Medicare Part B to provide benefits for such services as physician visits and supplies.

With DC 37 Med-Team Senior Care, you can go to any provider. If you go to providers who accept Medicare and the services are covered, the plan will cover all but a \$50 deductible per person per calendar year. If you go to providers who do not accept Medicare, you may have more out-of-pocket expenses. Each Medicare Part A inpatient hospital admission is subject to a \$100 deductible.

Some services are subject to deductibles, copays, and maximum benefits.

Precertification: Certain services require precertification. Failure to comply with the pre-certification requirements may result in a reduction of benefits.

For More Information

Please call GHI from 9 am to 5 pm, Monday through Friday, at 212.501.4444. If you have a hearing or speech impairment and use a TDD, call toll-free at 1.866.248.0640.

Cost

There is no cost for this plan.

For More Information

Please call the plan's service representatives at (212) 501-4444 from 8:30 a.m. to 4:45 p.m. any business day. When you call, please identify yourself as a DC 37 member.

You may write to:

DC 37

125 Barclay St.- 3rd Fl
New York, NY 10007

Elderplan

Elderplan is dedicated to providing affordable health care to seniors in Brooklyn, Queens, Staten Island and Manhattan. Elderplan is a non-profit Social Health Maintenance Organization operating under a Medicare Advantage contract. Medicare pays us so you don't have to.

As a member, you pay no premium beyond the Medicare Part B premium. Your care is delivered by a network of 36 hospitals and over 5,000 providers, and coordinated by a network-affiliated Primary Care Physician (PCP) of your choice.

Generous Benefits

Visits to your PCP are just \$10; when referred to a network specialist you pay \$15. Medically necessary hospitalization is covered with a \$200 co-payment per benefit period.

Prescription Drug Coverage

Prescription drug coverage is offered through the basic plan.

Retail: \$0 generic/\$25 formulary preferred brand/ \$60 non-formulary brand name/Greater or \$60 or 25% for a 30 day supply for biological purchased from an in-network preferred pharmacy.

Mail: \$0 generic/\$25 formulary preferred brand/\$60 brand-name drugs for a 90-day supply. Greater of \$150 or 25% for biologicals for 90-day supply through mail order.

Pharmacy benefit must be ordered from the plans formulary by a plan-affiliated physician.

Cost

There is no cost for this plan.

For More Information

Please call our Enrollment Services Department with questions between 9:00 a.m. and 5:00 p.m. at (718) 921-7898.

TTY for the hearing impaired
1-877-414-9015.

Or write to:
Elderplan
6323 Seventh Avenue
Brooklyn, NY 11231

Empire Medicare-Related Coverage

Empire Medicare-related coverage offers Medicare-eligible retirees protection from costly health care by filling the gaps in Medicare coverage. While Medicare Parts A and B cover hospital and medical care, most benefits are subject to deductibles or coinsurance. This Medicare Supplement plan helps retirees with Medicare Parts A and B avoid out-of-pocket costs by reimbursing the deductible and coinsurance amounts.

For More Information

For additional information about the program, please call 800-767-8672. Telephone hours are from 8:30 a.m. to 5:00 p.m., Monday through Friday.

Contact the plan at:
Empire BlueCross
BlueShield
City of New York
Dedicated Service
Center
P.O. Box 1407
Church Street
Station
N.Y., NY 10008-3598

For example, if you are hospitalized because you need surgery, the plan's hospital coverage, combined with Medicare Part A, provides benefits for room, board, general nursing, and other hospital services. The plan's medical coverage, with Medicare Part B, provides benefits for physician services and supplies.

Prescription Drug Coverage

Retiree must purchase the Optional Rider in order to receive the following prescription drug benefit.

Retail: \$10/\$25/\$50 and 25% for biologicals up to 30-day supply.
Mail: \$20/\$50/\$100 and 25% for biologicals up to 90-day supply.

Member pays copays up to \$2,830. After member reaches \$2,830 member pays 50% of the cost of prescription drugs up to \$4,550. After \$4,550 in out-of-pocket costs, member pays either \$2.50/\$6.30 copay or 5% coinsurance (whichever is greater).

Empire MediBlue HMO

MediBlue HMO is available to Medicare-eligible residents of the Bronx, Kings, Queens, New York and Richmond counties.

With MediBlue HMO, you will receive all the coverage provided by Medicare and most Medicare supplement plans combined, plus important extra coverage such as:

- No deductibles or coinsurance and no referral necessary to see a specialist (there is a \$0 co-payment for Primary Care Physician\GYN office visits and \$15 co-payment for Specialists and \$40 Mental Health visits, \$50 co-payment for Emergency Room visits, \$100 copay per day for days 8-90; \$0 copay for additional hospital days.
- \$100 allowance towards eyeglasses every 24 months**
- Free hearing exam once every 12 months
- \$1,000 towards two hearing aids once every 36 months
- Silver Sneakers, free membership to a participating gym
- Empire Healthlinesm, a toll-free health information hotline available to members 24 hours a day, 7 days a week

Prescription Drugs

Retirees who receive prescription drug coverage through their union welfare fund do not have prescription coverage through Empire MediBlue (HMO).

Retirees in union welfare funds where prescription drugs are not covered will automatically receive the following prescription drug benefit:

Retail: \$0 or \$10/\$30/\$60/30% for 30 day supply

Mail: \$15/\$75/\$150/30% up to 90 day supply

Member is responsible for co-pays up to \$2,840. Then unlimited generic coverage up to \$4,550. After Member reaches \$4,550, member then pays \$2.50 or \$6.30 copay or 5% coinsurance (whichever is greater).

For More Information

Call 1-866-395-5175 if you have any questions or to reserve a place at an information meeting in your community. Please identify yourself as a City of New York retiree.

Updated to reflect prescripton drug changes effective January 1, 2011.



GHI/EBCBS Senior Care

If you are a Medicare-eligible retiree enrolled in either GHI/EBCBS or GHI Type C/EBCBS, Senior Care supplements your Medicare coverage. After you have satisfied the Medicare Part B deductible, you will be responsible for an additional \$50 of covered Senior Care services per individual, per calendar year. GHI then pays the Medicare Part B coinsurance (that is, 20% of Medicare Allowed Charges) for covered services for that calendar year.

If you have EBCBS Senior Care, Empire BlueCross BlueShield supplements your Medicare coverage for inpatient hospital services, and pays the Medicare Part A inpatient deductible less a \$300 deductible per person per admission (maximum \$750 per year). Empire also supplements some hospital Medicare Part B coverage. Such as ambulatory/surgical procedures, Chemotherapy, Emergency Room Care. Emergency room coverage is subject to a \$50 copay. The Member is responsible for the Part B deductible.

For More Information

GHI
441 Ninth Avenue
New York, NY 10001
(212) 501-4444

Empire BlueCross
BlueShield
City of New York
Dedicated Service
Center
P.O. Box 1407
Church Street Station
N.Y., NY 10008-3598
1-800-767-8672

Optional Rider

From GHI:

Prescription Drug Coverage - Optional Rider

There is no deductible under this plan.

The plan will pay 75% (and the member will pay the remaining 25%) of eligible prescription drug expenses between \$0 and \$2,250. The plan pays 40% (and the member pays 60%) of eligible prescription drug expenses exceeding \$2,250 and less than \$8,895.83. After your total yearly drug costs reach \$2,250, you receive a discount on brand name drugs, until your yearly out-of-pocket costs reach \$4,550. After the member has \$4,550 of out-of-pocket costs, the plan will provide unlimited coverage of eligible prescription drug expenses subject to a member copayment which is the greater of 5% or \$2.50 for generic and brand drugs (that are multi-source drugs) and \$6.30 for all other drugs.

Beneficiaries must use network pharmacies to access their prescription drug benefits, except in non-routine circumstances, and quantity limitations and restriction may apply.

Open Formulary, Prior Authorization, Step Therapy and Quantity Level Limits all apply.

From Empire BlueCross BlueShield:

365-day hospital coverage.

Updated to reflect prescription drug changes effective January 1, 2011.



GHI HMO Medicare Senior Supplement

This Medicare plan is open to retirees residing in the counties of Albany, Bronx, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Kings, Montgomery, New York, Orange, Otsego, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, and Westchester in New York.

Retirees with both Medicare Parts A and B and age 65 and older are eligible for GHI HMO Medicare Senior Supplement. This plan provides the same comprehensive benefits of the standard GHI HMO program, and includes coverage for deductibles, coinsurance, and services not covered by Medicare Parts A and B, but not to exceed the standard coverage provided through GHI HMO's program. To be covered in full, Medicare-eligibles must use GHI HMO's participating physicians. If a non-participating physician is used, only Medicare coverage is applicable and treatment is subject to deductibles, copayments and exclusions.

For More Information

Retirees with questions about this coverage may contact GHI HMO Monday through Friday, 8:00 a.m. to 6:00 p.m., at 1-877-244-4466 or 1-877-208-7920 (TDD only). Or send your questions in writing to:

GHI HMO
PO Box 4181
Kingston, NY 12402

Attn: Customer
Service

Prescription Drug Coverage

There is a \$310 annual deductible under this plan.

Member pays 25% of eligible prescription drug expenses between \$310 and \$2,830. Member is responsible for 100% of the prescription drug cost between \$2,830 and \$6,440. If member reaches \$4,350.00 in out-of-pocket RX expenses, member will receive unlimited coverage of RXs subject to a copay of \$2.50 for generic/\$6.30 for brand drugs or 5% coinsurance (whichever is greater.)

Open Formulary, Prior Authorization, Step Therapy and Quantity Level Limits all apply.

Updated to reflect prescripion drug changes effective January 1, 2011.



HIP VIP® Premier Medicare

The HIP VIP® Premier Medicare Plan is available to residents of Manhattan, Brooklyn, Bronx, Staten Island, Queens, Nassau, Suffolk and Westchester counties. If you or your spouse are enrolled in Medicare Parts A & B, you are eligible to join HIP VIP® Premier Medicare Plan. You will receive all the benefits provided by Medicare, plus additional benefits provided by HIP.

As a member of HIP VIP® Premier Medicare Plan, you choose a primary care physician (PCP) practicing in his or her private office as part of our expanding network of physicians or in one of HIP's convenient neighborhood health-care centers throughout HIP's New York metropolitan service area. You may visit your PCP as often as necessary. Your PCP will refer you to appropriate specialists for treatment and services whenever necessary.

You and your dependents will be covered for a broad range of in-network hospital and medical services that include routine examinations, medical screenings, X-rays, mammography services, home care, urgent care, mental health services, a preventive dental program and more.

Any medical care – except for covered emergencies or urgently needed care out of the area – that is neither provided by nor authorized by HIP or your PCP will not be covered by either HIP or Medicare. Benefits vary based on county or residence. Please call HIP for more details.

Prescription Drug Coverage

Drugs are prescribed by your HIP participating physician and obtained through any one of HIP's participating pharmacies.

Retirees who receive prescription drug coverage through their union welfare fund are entitled to basic prescription coverage as follows:

Preferred Retail - \$10 Preferred Formulary Generic - 30 day supply; \$20 Preferred Formulary Brand – 30 day supply; 50% coinsurance Non-Preferred Generic & Brand Drugs; 25% coinsurance Specialty – Formulary, Generic and Brand Drugs.

Mail Order: \$15 Preferred Formulary Generic – 90 day supply; \$30 Preferred Formulary Brand; 50% copay Non Preferred Formulary and Brand per 30-day supply; 25% copay Specialty Formulary Generic and Brand.

Member pays copays and coinsurance listed above until reaching benefit limit of \$2,520. Member pays copays for Preferred Formulary Generic Drugs from \$2,520 to \$4,550. Member pays 100% of the cost for Preferred Formulary Brand, Non-Preferred Formulary Generic and Brand, Specialty Formulary Generic and Brand for drug costs from \$2,520 and \$4,550. When \$4,550 of (TrOOP) costs are met, member will pay the greater of \$2.50 for generic, \$6.30 for brand or 5% coinsurance.

Retirees in union welfare funds where prescription drugs are not covered will automatically receive the following prescription drug benefit:

At Retail: \$10 Preferred Formulary Generic – 30 day supply; \$15 Preferred Formulary Brand – 30 day supply; 50% coinsurance Non-Preferred Drugs; 25% coinsurance Specialty Formulary Generic and Brand Drugs.

Mail Order: \$5 Preferred Generic; \$7.50 Preferred Brand; 50% coinsurance Non-Preferred Formulary Generic and Brand; 25% for Specialty Formulary Generic and Brand.

If a member reaches \$4,550 in out-of-pocket expenses in a calendar year copays will then be \$2.50 per prescription for generic, \$6.30 copay for brand or 5% coinsurance.

For More Information

For additional information about HIP VIP® Medicare Plan please call:

1-800-447-6929.

Specially trained representatives will be available Monday through Friday 8:00 a.m. to 6:00 p.m. to answer your questions.

You can also log onto www.hipusa.com. Now available in English, Spanish, Chinese and Korean.

Humana Gold Plus Plan & Companion HMO

Humana Gold Plus plan offers all the benefits of Original Medicare plus extra services at no additional cost. If you are a retiree, eligible for Medicare, Humana has designed a health care plan especially for you in the following markets: In Florida: Daytona (Flagler, Volusia); Jacksonville (Baker, Duval, Nassau); Tampa Bay (Hernando, Hillsborough, Pasco & Pinellas); and South Florida (Broward, Dade & Palm Beach).

Advantages of Humana Medicare+Choice plans

New Member Specialist Program - If a member has a special need, a New Member Specialist will facilitate those services and will be available to answer questions about benefits.

HumanaHealth Personal Nurses - For members who may have the need for ongoing support from a nurse, Humana has a Personal Nurse service. The Personal Nurse works one-on-one with members who are seriously ill (or may become seriously ill), building long-term relationships with them and making it easier for them to understand and use the health care system.

Disease Management Programs - If you have a chronic condition, we want to help you avoid complications and improve the quality of your life. We have specific programs for many different conditions and continue to add more all the time.

Humana Active Outlook® - Each issue of this newsletter contains information that promotes healthy and active lifestyles. Members get easy-to-understand information including nutrition and exercise tips, and answers to commonly asked questions.

Health information at your fingertips - www.humana.com offers members a personal home page, MyHumana, giving them quick access to important benefits information and health tools. You can look up prescription data, benefit information and claims history, physician and hospital locations and much more. No claim forms or coordination of benefits. Worldwide coverage for emergency and urgently needed care.

Prescription Drug Coverage

Retail: \$10 generic/\$20 preferred/\$40 non-preferred/25% for biologicals for 30-day supply.

Mail: \$0 generic/\$40 preferred/\$80 non-preferred for 90-day supply. 25% for biologicals for 30-day supply.

Once member reaches true out-of-pocket costs of \$4,550, the member pays the greater of \$2.50 for generic (including brand drugs treated as generic) and \$6.30 for all other drugs, or 5% coinsurance.

Companion HMO Plan - Humana also offers a commercial plan designed for non-Medicare eligible dependents. To receive additional information for your dependent, please call (800) 833-1289.

For More Information

For more details or to request an enrollment kit, call:
(800) 833-1289
TDD 1-877-833-4486
between 8:00 a.m.-
8:00 p.m. EST-Monday-Friday.

A representative will help you with your questions and arrange an appointment with a Humana Gold Plus representative to complete your enrollment application.

Please identify yourself as a City of New York retiree.

SecureHorizons by UnitedHealthCare

If you are eligible for Medicare Parts A and B – and live in the five boroughs of New York City or Bergen, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic and Union Counties in New Jersey – then you can be a part of SecureHorizons, a Medicare-contracted Health Maintenance Organization. SecureHorizons offers you a comprehensive health plan with no deductibles, and virtually no paperwork.

Freedom to Choose Your Doctor

When you join the plan you have the freedom to choose your personal doctor from our list of highly-credentialed private-practice physicians. The doctor you choose will become your primary care physician (PCP) and will work with you to coordinate all of your health care needs, including referrals to specialists and admissions to hospitals. Doctor visits are \$15 and your annual physical is free. Chiropractic visits are subject to 50% coinsurance. As a SecureHorizons Member, you'll receive full coverage for hospitalization when arranged or authorized by your PCP. And, in the case of an emergency, members are covered anywhere in the world.

SecureHorizons encourages its members to take care of themselves, which is why you are entitled to a free annual physical, free annual dental checkups (with discounted dental care), free yearly mammograms and Pap smears for women, as well as podiatry, vision and hearing aid benefits.

Prescription Drug Coverage

Retirees who receive prescription drug coverage through their union welfare fund are entitled to basic prescription coverage as follows:

Retail: \$4/\$28/\$58/\$33 to \$2,830 with Part D "donut hole" up to \$4,350 (member Responsible for 100% of RX cost up to \$4,550.)

Mail: \$8/\$74/\$164/33%

If a member reaches \$4,550 in true-out-of-pocket costs, member will pay the greater of a \$2.50 copay or 5% coinsurance for generic drugs or the greater of a \$6.30 copay or 5% coinsurance for brand name drugs whether purchased at retail or mail order.

Retirees in a union welfare fund where prescription drugs are not covered will automatically receive the following prescription drug benefits:

Retail: \$4/\$20/\$40/\$40

Mail Order: \$8/\$50/\$110/\$120

Mail order and retail copays up to \$4,550. If a member reaches \$4,550 in true-out-of-pocket costs, member will pay the greater of a \$2.50 copay or 5% coinsurance for generic drugs or the greater of a \$6.30 copay or 5% coinsurance for brand name drugs whether purchased at retail or mail order.

For More Information

If you have any questions about SecureHorizons, please call: 1-800-203-5631, Monday- Friday, 9:00 a.m. - 5:00 p.m. Please identify yourself as a City of New York retiree.